State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician ELLIGT 20 0729 AM NAM 2004 LINDA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 25, 1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🕅 F 55 Director 217-46-4611 Maryland Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. ordent: If tem 27 is marked other than "naturel", or iteme 23a or 28a-f show injury or other traumatic event, the Medical Examine must be rotified at 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Carroll Westminster 10g. Citizen of What Country? 10f Zip Code 10e Street and Number 2135 Fridinger Mill Road 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2 Yrs Elementary/Secondary (0-12) Yrs Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 John Joseph Eckman Doris Jeanne Gougler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21157 2135 Fridinger Mill Road James R. Elliott, Sr. Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 5/24/04 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 360 ensens leen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventually fibrillation **Physician** 30 minutes /Medical Due to (or as a consequence of): Examiner Coronary artery WELLIS disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit The law requires that the death certificate be executed Attulvus deloses 4:0.45 Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA P 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation s after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hoepital o within 24 hours aft To the Funerel Di completely filled in SC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NID RES 000 MALLI 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PADINE JACKSON MD 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21205 JOHNS HOPKINS HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 2 4 2004

				State of Maryland					_	
			1 - For State Registrar	otato or marytano	•	tificate of D			No2006	16502
	Dhoris		1. Decedent's Name (First, Middle, Last)	^		-		2. Date of Death Month		3. Time of Death
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	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or I	Location of Death		4c. County of Dea	th (// /
	<b>5</b>		6. Social Security Number 6. Sex		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Rir	tholace (State or Foreign
	Funeral Director			M 2 F	Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) Co	thplace (State or Foreign buntry) UBELIA
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10.00	T					,
	shov	ō	10a. State 10b. County		Town or Lo	cation IMORE	,			10d. Inside City Limits 1 ☑Yes 2 ☐ No
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	3a or	by Funeral Director	628 E. 35TH	STREET			218	1.03	LIBE	
	ems 2	ner	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	. 13. \	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-	14. Race - Ami Black, Whi	
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5-0036	72 hours after death with the Maryland natural', or Items 23a or 28e-f show Ilical Examinat must be notified at	q pa	3 Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	16a Decer	ient's Usual Occupat	tion	10	b. Kind of Business	
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21	od with	Completed	12th grade	N/A	PI	ouce of	FICER		West A	FRICA
pu	be file	To Be	17. Father's Name First, Middle, Last)	- 10			18. Mother's Name			
3	hould d Mer narke natic	5	JIMMY GREE  19a. Informant's Name/Relationship (Type		40h 14-16-				GRAN	
Maryland	th and 2 si		ANNIE BERRY		196. Mailin	g Address (Street ar				UD 21218
	s 1 ar if Hea itam other		20a. Method of Disposition UNK	20b. Pla	ce of Dispo	sition (Name of	D			Town, State HPIK
E	Page nent o ent: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	netery, crem	natory or other place	- C(1		Baito r	nD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any jointy or other traumatic event. Ite Medical Examinat must be notified at once.		21. Signature of Funda Service License	4	22	Name and Address	of Facility			
_	205 29		Vange C	<b>_</b>	5	S BALTIM	ORE NATIO	:NAL PIKE	BAUTO M	D 21229
4			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death. e cause on each line.	Do not ente	er the mode of dying	, such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) cast	Due to (or as a conseque	ncellof):	401	/ /	lom &		
687	icate physi s the I	dlcal	d.	JA C	1 2	Musi	est elle	Jun 9		
Box (	leath certific attending p I for use as 1	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnance					23d. Date of de	livery
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Vital	sician: Th certificate rector, pag	e Co	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2 🕽	No 1□Yes	2 No
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n of	ding Phy h. After this funeral o		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	28c. Injury	at 2	8d. Describe how	injury occurred	
sio	ttandi Jeath. tor: A the fu	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				es 2 🗆 No			
Division	l or A	Certification;	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, tarm, stre	eet, factory, office	2	City or Town, S	et and Number or R. State)	ural Houte Number,
	spita nours narel		29a. Certifier 1 Certifying Physi	cian: To the best of my knowl	edge, death	occurred at the time	a, date and place, a	and due to the caus	se(s) and manner as	s stated.
	he Ho in 24 f he Fu pletely	Medical	(Check only 2 Medical Examination)	er: On the basis of examination and manner stated.	n and/or inv	estigation, in my opi	nion, death occurre	ed at the time, date	and place, and due	e to the cause(s)
	To the Hospital or Attanding Pr within 24 hours after death. To the Funarel Diractor: After the completely filled in by the funera	Σ	29b. Signature and title of certifier	MO		29c. License		29d	. Date signed (Mont	h, Day, Year)
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	1		30. Name and address of person who con	npleted cause of death (Item 2	(За) (Турв, 1 СТАС	Print) (C,	BACTIM	ORE M	172121	7
	. Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu		1			\.	/
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			1 - State Registrar	State of Mar		partment of Certificate of			iene 99. No. 200	4 16503
	Physici /Medic		1. Decedent's Name (First, Middle, Last Helen May G					2. Date of Deat Month May 22,		3. Time of Death
}	Examir		4a. Facility Name (If not institution, give 103 Embleton R	d.		Owings	or Location of De		4c. County of De Baltin	
	Funeral Director		5. Social Security Number 6. Se 212-01-9469		In yrs. last birtho	Months Days			1914 Ma	irthplace (State or Foreign Country) aryLand
	Maryland	tor	10a. State 10b. County Md. Baltimo		Oc. City, Town o	r Location S Mills		_		10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23s or 28s	al Director	10e. Street and Number 103 Embleto	n Rd.		10f. Zip Code 21	117	1	0g. Citizen of What (	-
920	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show he Modical Examinan hast be rodiffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ XNo	ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black, Wi	nerican Indian, nite, etc. Nhite
21215-0036	filed within 72 ho Hygiene. ther than "natui int, Ine Medical	Completed	15. Decedent's Edi (Specify only highest grad	cation e completed) College (1-4or 5+)	(6	ecedent's Usual Occi live kind of work don fe. DO NOT use retir Bindrey w	e during most of w ed)	vorking	16b. Kind of Busines Printin	
Q	filec Hyg othe	To Be C	17. Father's Name (First, Middle, Last) Harry Schiss	ler				ame (First, Middle, M	Maiden Surname)	
e, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If itam 27 is marked any injury or other traumatic as once.		19a. Informant's Name/Relationship (T)  Diane L. Shoemak  20a. Method of Disposition		ter 103	,		Rural Route Number, rings Mill Date	-	117
Baltimore,	nit. Pages artment of ortent: If it injury or o		1 ⚠ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		cemetery,	crematory or other pl	tery Ma			stown, Md.
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	Physician /Medical	i	shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Λ.	chemers	Dem.	entiq			Interval Between Onset and Death
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8760,	sate be executed physician and the burial-transit	dical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
.O. Box 6	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 d 4 ☐ Pregnant at tin 9 ☐ Unknown	☐ Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of o	lelivery Day Year
<u>α</u>	sign sign d be	by	Part II. Other significant conditions co	ntributing to death but i	not resulting in th	e underlying cause g	iven in Part I.	23e. Did tot		to the cause of death?  Probably 4 □Unknown
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Division of Vita	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funaral Diractor: After this certificate completely filled in by the funeral director, pag	ertification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No   1  27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day Y	'ear) 28b. Tim Inju	e of 28c. Injury W 1[	ther: 4 Nursing ury at ork? Yes 2 No		ence 6 □Other (Sp ow injury occurred	
DİVİ	pital or Attendurs after deathurs after deatharal Diractor:	O	4 Homicide determined	building, etc. (	(Specify)	, street, factory, office		City or Town	n, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funaral Completely filled	Medical	29a. Certifier (Check only one)  2 ☐ Medical Exami  29b. Signature and title of certifier	sician: To the best of a ner: On the basis of ea and manner state	kamination and/o	r investigation, in my	time, date and pla opinion, death oc nse number	curred at the time, d	ause(s) and manner ate and place, and d ———————————————————————————————————	ue to the cause(s)
	h		1 Calu	( ) any						72 21211
	J		30. Name and address of person who co	DIAMA		pe, Print)	Falls	Red 6	Baltimore	ML 21211
	Sta Registr	., .	MAY 2 4 200	4 Atrice	B	spork	V			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Virginia Green /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 29, 1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Hours **Funeral** Months Days 1□ M & F Maryland 214-20-8354 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28e-1 ehow the Medical Examiner must be notified at 1 ☐ Yes 2 → No Director Maryland Baltimore Lansdowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 3249 Ryerson Cir. 21227 U. S. A. or iteme 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after ☐ Yes 2☐ No f Yes, Gîve X 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary E. Callahan Leonard Sheubrooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen Nugent, daughter 3249 Ryerson Cir. Lansdowne, MD. Item 27 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cometery, crematory or other place)
MD Veteran Cemetery 20a. Method of Disposition Department of H Important: If Ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 05-21-04 Elkridge, MD `4 ☐ Donation 5 ☐ Other (Specify) Crownsville 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, shock, or heart failure. List only one cause on each line. MD. 21227 Approximate Interval Between Onset and Death Immediate Cause (Final KESPIRATORY 24 LOURS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** vere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi MISTOPS -ONG Due to (or as a consequence of): ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 monthe? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 23e. Did tobageo use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ NON-1 Yes 2 □ No MSULIA 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 HO 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA Certification; To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by or A after 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Box 68760 Ö Records, Division of Vital within 24 hours a To the Funeral L Hospital

Saltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

completely

Medical

(Check only one)

29b. Signature and title of certifier an

31. Date filed (Month, Day, Year)

MAY 2 4 2004

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MACHIRAN

720-C MAIDEN

29c. License number

TTENDING MYSICIAN

it. Pegas 1 end 2 should be filed within 72 hours efter outment of Heelth end Mental Hygiene.
rtant: If ftem 27 is marked other than "naturel", or ites
njury or other traumatic event, the Medical Examina Baltimore, Maryland 21215-0020 Physician /Medical Examiner or Attanding Physician: The lew requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760.

**Physician** 

Examiner

**Funeral** 

Director

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be notified at

Completed by Funeral Director

Be

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MD

/Medical

by Physician/Medical Examiner cate has been signed by the attending physician and page 2 should be detached for use es tha bunal-trensit Be Completed versi Director: Aftar this cartific fillad in by the funerel director, Medicai Certification: To

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Part II. Other significant con

examiner 1 ☐ Yes 2X No 27. Menner of Deeth 1 X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide

29a. Certifie

(Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

D54749

29d. Date signed (Month, Day, Year)

MAY 19, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of deeth (Juny 23e) (Type, Print)

801 TOLL HOUSE AVENUE, D-1 ALLEN REILLY, M.D.

FREDERICK, MD 21701

State Registrar 31. Date filed (Month, Day, Year) MANY 2 4 2004 32. Registrer's Signature

efter death Director:

24 hours e

within 24 ho To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM #21 PERH C831 5/26/04 III

State of Manyland 1 Department of Health and Mental Hygiene

1- State Amend Trem 8 per ft (8845 9-15-05 Las
Registrative ND TIEM \$200 PER FH (8831 5/24/04 dertificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Holmes Year Month **Physician** Develor 20th 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County General Hospula Collma If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adapthe Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 217-14-9250 Hours 10**X**(M 2□ F MD 4-4-1921 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 77 ie markad other than "natural", or Itema 23a or 28a-f eho: traumatic event, tra Medical Exandray must be motified at HOWARD MD 1 ☐ Yes 2 No Funeral Director COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 TRICROSS DRIVE USA 5621 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ACK 1 ☐ Yes 2 X No Specify: BL Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 ie marked other thu any injury or other traumatic event, Ifa. pncs. ANNE ARUNDELCOUNT 4th grade NIA DRIVER RUCK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be VERNETTA DOTSON RUFUS HOLMES ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5621 TRICROSS DRIVE COLUMBIA MD 21045 NAOMI HOLMES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 BBurial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD. DUDON PARKI \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICES
5151 BALTIMORE NATIONAL PIKE BALTO MD 21229 VALCEN GREENE PER INR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final tastalu lung canier Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequent of): Examiner death certificate be executed and Due to (or as a consequen of): zuluce the attending physician osene Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed?

1 Yes 2 No certificate director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 50370 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Carl Clarify and Bell Lane Clarify all MD 2029

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 4 2004

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 2001

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	Diam'r.		1. Decedent's Name (						-		2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Joan	Marie		rndon					May	16 2	2004	10:15 AM
	Examin	er	4a Fecility Name (If n	-		)				4b. City, Town, or I				
			10937 Whi			no (In um	last birthday)	If Unde	r 1 Year	Potomac If Under 24 Hrs.			1tgome	J
	Funeral Director		5. Social Security Num 232-20-978 Usual Residence of December 1	7	™ 257F	82	Yrs.	Months		Hours Min.	8. Date of Bir (Month, Da Nov. 1			ce (State or Foreign v) Virginia
	show the state of			0b. County		10c. City	y, Town or Lo	ocation					100	I. Inside City Limits
	W Per W	5	Maryland	Montgon	nery			_	thes	da				1 ☐ Yes 2 ☐ No
	Men th	吉	10e. Street and Numb					10f. Zi	Code			10g. Citizen of \		
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20		by Funeral Director	1 Never Married 3 ☑ Widowed 4		Armed Forces  1  Yes 2  if Yes, Give Year or Dates:	? No	1			lispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Bla Specify	ck, White, etc	<b>2.</b>
Maryland 21215-0020	72 hou	Completed by	15	5. Decedent's Ed only highest grad	ucation		16a. Dece	dent's Usu	al Occup	nation during most of wor	rkina	16b. Kind of B	usiness/Indu	stry
12	Within the state of the state o	쿹	Elementary/Second		College (1-4or	5+)	life.			during most of word)		D		
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<u>'an</u>	ked be	To Be	Andrew	John	l	Zieg	gler			Cathe	rine		Wick	
ary	ond &		19a. Informant's Nam	e/Relationship (7	ype, Print)		19b. Maili	ng Addres	s (Street	and Number or Ru	ıral Route Numb	er, City or Town,	State, Zip C	ode)
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aitimore,	Pages 1 nent of H int: if iter iry or off		20a. Method of Dispos 1 ☐ Burial 2 🔯 0 4 ☐ Donation 5	Cremation 3	Removal from State	, ,	lace of Dispo emetery, cre sapeal			ory Inc.	May 25 2004	Belts	ville,	
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B	Examiner	_	resulting in death)		a		r as a consec	quence of)	0	/		10	i	1.1
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o,	an en uriei-tr	Ä	Sequentially list condi- if any, leading to immediate. Enter Underly Cause (Disease or injuthat initieted events	ediate ing	ath	2 VO	- 0	0.00	FC	,			0	Id.
68760,	tificate be executed g physician end es the buriel-transit	es es	that initieted events resulting in death) Las	st	c	-	as e consec	quence of):						(0)
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o.	requires that the death cer seen signed by the ettendir hould be deteched for use	Physician/N	Part It. Other significa	int conditions co	intributing to death i	out not resu	alting in the u	inderlying (	ause giv	en in Part I.				he cause of death?
Ś.	gned be de	Š												
Soro	_ 10 10	Completed by										an autopsy prmed?	availa	autopsy findings able prior to pletion of cause ath?
E I	The lew ate has b page 2 s	Ĕ									10	Yes 2 No	101	∕es 2□ No
<b>#</b>	entific actor,	å	25. Was case referred examiner?	- +					l ou	26. Place of Dea	th (Check only o	one)		
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ا ا	After funer	Ë		5 Pending investigation	28a. Date of thi		28b. Time o Injury	м	28c. Injur Wor 1 □	yat k? Yes 2 ∐ No	28d. Describe	how injury occur	red	
É	l or Attending Physicien: after death. Director: After this certific d in by the funeral director.	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	286. Place of in	jury - At ho lc. (Specify					28f. Location (	Street and Numb wn, State)	per or Rural F	Route Number,
_ :	To the Hospital or Attending Physicien: The lew Within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1[ (Check only 2[ one)	Certifying Phy Medical Exam	rsician: To the best iner: On the basis of and manner s	of examinat	vledge, deat ion and/or in	h occurred vestigation	at the tir , in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	anner as stat and due to th	ed. ne cause(s)
	Within To the	ŝ	29b. Signature and title	e of certifier	1			29		e number		29d. Date signe		-
			► NO	lbide	ND				D3	1319		May 1	8, 200	)4
	10	1	30. Name and address											
	10		Loreto Al					ve.,	Beth	esda, MD	20814			
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0		1 - For State Registrar	State of N	aryland	l / Depa	artment of He tificate of D	ealth and N	nental Hyg	iene g. No. 200	
Phy≼ic /Med	cal	Decedent's Name (First, Min Walter  4a. Facility Name (If not institute)	E. Ham	pton	Sr.	4b. City, Town, or I	ocation of Death	2. Date of Deat May 23	2004 Yea	6:50 A M
Exami Funeral Director		Charlestown 5. Social Security Number 090-01-5810	Ret. Cent		st birthday) Yrs.	Catonsv  If Under 1 Year  Months Days		8. Date of Birth (Month, Day, Sept 2	Balti	
		Usual Residence of Decedent  10a. State 10b. Cour  Md. Balt	nty <b>imor</b> e		Town or Lo	cation sville		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits 1X Yes 2 □ No
Maryland 21215-0036 of 2 should be filed within 72 hours after death with the Maryland th and Mental hygiene. It is marked other than "netural", or Items 23s or 28e-f show traumatic event, the Madical Exemples must be notified at	To Be Completed by Funeral Director	10e. Street and Number  719 Maiden Cho  11. Marital Status  1 Never Married Marital Status  1 St	12. Was Deceder Armed Forces	? ]No :	16a. Deced (Give life. Certi	10f. Zip Code  21228  Was Decedent of His fyes, specify Cuban  1 Yes 2 No  dent's Usual Occupat kind of work done of DO NOT use retired  fied Publ	Specify:  ion ring most of work  ic Accou  18. Mother's Nam  Grace	ecity Yes or No- Rican, etc.)  ing  ntant  e (First, Middle, M.  Johnst	Black, WI Specify:  16b. Kind of Busines  Tire/Rubb  faiden Sumame)  On	white str. White sylndustry er Products
Baltimore, Ma permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau once.		Walter E. Hamp 20a. Method of Disposition	on 3 □Removal from State (Specify)	cen	506 ce of Disponetery, crer view	Moorings sition (Name of natory or other place) Cemetery Name and Address 111 Mount	5/29	Arnold,  Oate /  /04 W  llings F	Md. 21012 coc. Location - City of estfield, uneral Ho	New Jersey me PA
3760, ate be executed Wedical Wascian and he burial-transit	ical Examiner	23a. Pah1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Dus to (or a c.		ence of):	er the mode of dying,			st,	Approximate Interval Between Onset and Death
Box 68. death certific e attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗀 Fetal d	leath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
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tision of Vital ttending Physicien: death. ctor: After this certifica	Certification; To Be C	3 Suicide 6 Cou	Hospital: 1 □ Inpai  28a. Date of In  (Month, D  stigation  Id not be  28e. Place of In	ay Year)	8b. Time of Injury	t 3 DOA Other 28c. Injury a Work?	ursing Hoat	h (Check only one me 5 - Reside 28d. Describe ho	nce 6 Other (Sp. w injury occurred	
DIVI To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medic	ying Physician: To the bes al Examiner: On the basis and manner:	of examinatio	edge, death on and/or inv	occurred at the time restigation, in my opin	, date and place, nion, death occurr	and due to the ca red at the time, da	use(s) and manner at te and place, and di	as stated. ue to the cause(s)
THE TO BE	<b>X</b>	29b. Signature and title of cert		double the	120) (7:	29c. License			d. Date signed (Mod	
St Regist	ate rar	30. Name and address of pers  May 2 4  31. Date filed (Month, Day, Ye	coenter N	death (Item 2	(Type,	D309 Widen Cl	noice l	n Cad	previll	2 MO

		-	State of Maryland / Department of Hea  1 - State Registrar		ental Hygier	Z 11 11 14	16510
	Physicia	an	1. Decedent's Name (First, Middle, Last)  John Lee Iseman		2. Date of Death Month	ay Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number).  Baltimore VA medical Center Baltimo	cation of Death		2/ 2004 tc. County of Death n/a	12:50 pM
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 6 / 2 / / 4 2	9. Birth	place (State or Foreign INSYLVANIA
	inyland show		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Ma 28e-1 s	Director	MD n/a BALTIMORE  10e. Street and Number 10f. Zip Code		100.6	Citizen of What Co	1 XYes 2 □ No
	h with 23e or		105 S. CURLEY STREET 212	24		USA	,
36	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumatic event, I're Medical Examinational Be notified at ance.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Marital Status  1 Mas Decedent of Hispan If Yes, specify Cuban, M  1 Marital Status  1 Mas Decedent of Hispan If Yes, specify Cuban, M  1 Mas Decedent Ever in U.S. Armed Forces?  1 Mas Decedent Ever in U.S. Armed Forces?  1 Mas Decedent of Hispan If Yes, specify Cuban, M  1 Mas Decedent Ever in U.S. Armed Forces?  1 Mas Decedent Ever in U.S. If Yes, specify Cuban, M  1 Mas Decedent of Hispan If Yes, specify Cuban, M  1 Mas Decedent of Hispan If Yes, specify Cuban, M  1 Mas Decedent Ever in U.S. Armed Forces?  1 Mas Decedent Ever in U.S. Armed Forces?  1 Mas Decedent Ever in U.S. Armed Forces?  1 Mas Decedent of Hispan If Yes, specify Cuban, M  1 Mas Decedent of Hispan If Yes, specify Cuban, M  1 Mas Decedent Ever in U.S. Armed Forces?	nic Origin? (Spe dexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: T.:	
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Maryland 21215-0036	within 7 ane. than "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  SHIPPING & RE			DHESIVE	
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ylar	should be nd Mental marked o umatic eve	To		ANN	/ Sauta Musaba - Cita	Town Chair 7	- Code)
	and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship (Type, Print)  MRS. PATRICIA ISEMAN  105 S. CURLEY				D. 21224
Baltimore,	Pages 1 and the control of Head and: If item		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  1  Donation 5 Other (Specify)			Location - City or LTIMORE	
Balt	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee  KACZOROWSKI  1201 DUNDA	LK AVE	BALTIM		21222
			23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.	uch as cardiac or	r respiratory arrest,	,	Approximate Interval Between Onset and Death
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O. Box	death cer e attendir ed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ 9 □ Unknown			23d. Date of deli Month	very Day Year
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of Vital Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed	renal failure		24a. Was an autopsy performed 1 Yes 2 🕰	prior to death?	topsy findings available completion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	examiner?		(Check only one)		
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Division	al or Attendi after death. I Director: A d in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical C	29a. Certifier (Chack only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, of examination and/or investigation, in my opinion and manner stated.				
00	To ti To ti comp	Ž	29b. Signature and title of certifier 29c. License nu			Date signed (Mont)	
	(x)		Melle Liverthe market mb 0005  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6534	3 1	107 21,	2007
	X		Deb-a Lucille malore m.D., 10 North Greene ST	tweet	Baltimore	e maryla	and 21201
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 2 4 2004  MAY 2 4 2004				

			For State Registrar	State of i	Maryland /	Depa <i>Cer</i>	artment of I tificate of	lealth ai		R	eg. No.	004	16511
	Physici	an	1. Decedent's Name (First, Middle, L						-	Month	Day	Year	3. Time of Death
20	/Medic	al	Jo Ann Ruth Jac  4a. Facility Name (If not institution, g		ner)		4b. City, Town,	or Location of		May 19	_	nty of Death	9:55 P <sup>™</sup>
	Examin	er 6	102 Carol Ave		,			Aberde			Har	ford	
je.	Funeral			Sex 7.	Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day)	Year)	9. Birtho	place (State or Foreign
	Director		380-34-5295 Usual Residence of Decedent	201		Yrs.				May 3,	1935	MI	
	Moi Moi		10a. State 10b. County		10c. City, Tox	wn or Lo	cation					1	10d. Inside City Limits
	a-fah	ctor	MD		Aber	deen							1 ☐ Yes 2 ☑ No
	or 28	Dire	10e. Street and Number				10f. Zip Code			1	0g. Citizen o		
	s 23a	rai	102 Carol Ave	10 Mar Band	ant Francis II C	10.1	21001	Ulinania Odel	-2 /5	h. Van an Na		d Stat	
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. In Internate 18 marked other than "natural", or items 23a or 28a-f show many injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Volvorced	12. Was Decede Armed Force 1	es?	'	Was Decedent of I f Yes, specify Cub I ☐ Yes 2 No	an, Mexican,	Puerto Ric	ry Yes or No- can, etc.)		lack, White,	etc.
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2	iled w Hygier Iher ti		17. Father's Name (First, Middle, La		F	ACCO	ıntant	18 Mother	's Name //	First, Middle, i	Maiden Sum	amel	
Maryland	d be id  o Be	Linford H. Ende					Ruth						
ary	shou and M mar umat	۲	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailir	g Address (Stree	t and Number	or Rural P	Route Number	r, City or Tow	m, State, Ziç	Code)
Ž	and 2		Cynthia England	/Daughter	I	2.0.	Box 52	, Havre	e de	Grace,	MD 21	.078	
Baltimore,	of He		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from St	comot	of Dispo ery, crem	sition (Name of natory or other pla	ice)	Dat Ma	e ay 21	20c. Locatio	n - City or To	own, State
tim	t. Peg tment tant: ijury o		`4 □ Donation 5 □ Other (Spec	cify)			ke Crema			004		ville,	MD
Ba	Depermine Depermine Important Import		21. Signature of Funeral Service Lic	lell-	Mooret		Name and Addr Crematio 8717 Gre	en Pas	tures	Drive	Bal		Approximate
8760,	Physician / Medical Examiner  the parial-transit	licai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence	a of): e of):	-ROE	CEU		-9mi	HO	n#	Signature of the second of the
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown		h 2 Fetal deat it at time of death		Ectopic pregnanc Other (specify)	y				Date of delive	ery Day Year
۵.	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to deal	th but not resulting	in the ur	nderlying cause gi	ven in Part I.			bacco use co		he cause of death?
Records,	The ate h	Completed							_	24a. Was a autops perform	med?	prior to co death?	opsy findings available impletion of cause of
Vital	iclan: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?						of Death (	Check only on			
ō	ling Phys I. After this uneral du	tion: To	1 Yes 2 No  27. Manny of Death 1 atural 5 Pending 2 Accident investigat	Hospital: 1 Inp 28a. Date of (Month,		Outpatien Time of Injury	28c. Inju		280	5 Vileside d. Describe ho			у)
Division	in the	Certification:	3 Suicide 6 Could not determine	ad 200. Place of	Injury - At home, , etc. (Specify)	farm, str	eet, factory, office		281	Location (Si City or Town		nber or Rura	al Route Number,
1/	To the Hospitel or At within 24 hours after of To the Funerel Direct completely tilled in by	edical (	29a. Certifier (Check only one)	Physician: To the bo aminer: On the bas and manner	is of examination a	ge, death and/or inv	occurred at the trestigation, in my	me, date and opinion, death	place, and occurred	d due to the cat the time, d	ause(s) and ate and plac	manner as si e, and due to	tated. o the cause(s)
•	To the complete	W	29b. Signature and title of certifier	Elm	who y	n.	) . 29c. Licen	3/7	75	2	9d. Date sign		21047
	0		30. Name and address of person when the second seco	SWAR	of death (Item 23a	(Type,	Print) 2/1	us T	ON	AIR	RU	4DAn	10 21047
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 4 2004	82. Reg	gistrar's Signature	jl.	bush	U.		ŧ	•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1025 AM MAY LINWOOD NORMAN JACKSON 2004 /Medical SR. 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE If Under 24 Hrs. 8 NORTH ARUNDE ANNE HOSPITA GLEN ARUNDEL If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1**€**XM 2□ F MD (Country) 218-01-4722 87 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Completed by Funeral Director MDANNE ARUNDEL MILLERSVILLE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 260 JUMPERS HOLE ROAD 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√2 No BLACK Specify: WWII 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiane. STEAMSHIP Elementary/Secondary (0-12) College (1-4or 5+) 7TH LONGSHOREMAN TRADERS UNION permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event
2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEROY JACKSON CLARA ROLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21/0 8 LINWOOD JACKSON, JR. 260 JUMPERS HOLE RD, MILLERSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ASBURY CHURCH CEM 5/26/2004 A.A. COUNTY, M.D. 21. Signature 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AV, BALTO, Nenter the disease, or complications that caus ock, or head failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death iate Lause (Final neumonsa **Physician** condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resultingly the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by page 2 should be sloma Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25 No 1 🗌 Yes 25 No Division of Vital 1 Yes Hospitel or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide In Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one)

State Registrar KOF

29b. Signature and title of certifie

31. Date filed MAY. 29.4 ear 2004

15

017

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

t

3. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2004

			1 - For statemend item 11 Registrar	State per wife	<b>of Ma</b> r g843 5/	yland / /13/05 a	Depa	artment rtificate	t of H	ealth a Death	and M	lental Hy	giene Reg. No	20	Πlı	165	13
	Physici	an	1. Decedent's Name (First, Midd	le, Last)	-							2. Date of De. Month MAY 1.	ath		Year	3. Time of De	
1	/Media		Marlon  4a. Facility Name (If not institution		number)			James 4b Civ		Location of	of Death	PPAI I.		. County o	of Death	6:26	P ""
	Examir	er	NORTHWEST HOSE		mumber)			R	ANDA	LLSTO	NWC			ALTI		$\infty$	
	Funeral Director		5. Social Security Number 070–78–7670	6. Sex 1 [X]M 2 □ F		(In yrs. last b 39	virthday) Yrs.	If Under Months	1 Year Days	Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 4-1-6	y, Year)		Coun	ace (State or Fi iry) idad, W	
	DL &		Usual Residence of Decedent  10a. State 10b. County	,	1	IOc. City, To	wn or Lo	eation								d. Inside City L	
	Aaryla ed en	ŏ				oo. Oily, To									''	1X Yes 2	
	28a-	rect	Md.  10e. Street and Number				Ba.	Ltimor 10f. Zip					10a. Cit	izen of W	hat Coun	try?	
	death with the Maryland ms 23a or 28a-f ehow I must be notified at	io is	6800 Liberty	Rd.					207					USA			
	deatl	Funeral Director	11. Marital Status	12. Was D	ecedent Ev   Forces?	er in U.S.	13.	Was Deced	ent of His	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race	- Americ		
36	hours after tural, or ite	by Fu	1 Never Married 2XXMar	rned 1 ☐ Ye	s 2 XNo Give			1 🗆 Yes 2		Specify:	i, i doito	Thous, etc.)		Specify:			
Ö	hours tural		3 Widowed 4 Divorced	Year o	or Dates:	16		dent's Usua		tion			16h K	ind of Bus	Бта		
5	n "nat	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade complete			(Give	kind of wor DO NOT us	k done d	uring mosi	t of work	ing	100. K	Ind of Bus	siness/inc	ustry	
212	e filed within al Hygiene. I other then "	mo	12th grade	Colleg	e (1-4or 5+)		Cons	struct	ion	Wo	rker			Vari	es		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23s or 28s-f show other treumatic event. The Medical Examinar must be rotified at	Bec	17. Father's Name (First, Middle	Last)						18. Mothe	er's Name	e (First, Middle,	Maiden	Sumame	9)		
yla	2 should be f and Mental I is marked of reumatic eve	2	Henry		Jā	ames					onne				ustu		
Mar	12 sh hand 7 is rr treum		19a. Informant's Name/Relation: Yvonne James	ship <i>(Type, Print)</i>		19						Al Route Number				Code)	
	of Health Item 27		20a. Method of Disposition			20b. Place	of Dispo	sition (Nam	e of			3, Broo		ocation - C		wn. State	
no	ages int of t; if it		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (		om State	cemet	ery, crei	natory`or ot Green	her place		5–27	-04			,	, N.J.	
Baltimore,	permit. Pages Department of Importent; if i any Injury or o		21. Signature of Funeral Service		4 -	1010	22	2. Name and	d Addres	s of Facilit	у	Bal	timo	ore,	Md.	21202	
	<b>4</b> 0 = € Ø		-ran	-1/	fee	× /		March						Nort	h Av		
			23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	t only one cause o	n each line.				_	4		or respiratory ai	rest,			Approximate Interval Betwee Onset and Dea	
	Physician /Medical		disease or condition resulting in death)			27 TI		4130	5MB	DUSV	1						
R	Examiner			Due Due		cońsequence EG \	e or):	N TI	trou	ial Si	5						
		Jer	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	D		-UnisequeTide			- ( 01								
	cuted nd ransit	Examiner	that initiated events	C													
60,	be executed sician and burial-transit	E Ex	resulting in death) Last	Due	to (or as a	consequence	e of):										
928	phy:	dicai		d											-		
Вох 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of									23d. Date	of delive	rv	
	that the death led by the atter detached for L	iciai	in the past 12 months?	4□Pr	egnant at tir	Fetal deat me of death		Ectopic pre Other (spe					Ì	Mon		Day Yea	,r
P.0	by the	hys	9 🗆 Unknown	9L Ur	nknown								Į				
	og Jg	by	Part II. Other significant conditi	ions contributing to	o death but	not resulting	in the u	nderlying ca	use give	n in Part I.						e cause of deat ably 4 □Unk	
öre		etec															
Vital Records,	has has	Completed				<u> </u>								pr	ior to con	sy findings ava ipletion of caus 2□ No	e of
/ita	Physician: The this certificate al director, pag	Be	25. Was case referred to medica examiner?	-							of Death	(Check only o					
of	Physic this c	은	1 XYes 2 □ No		Inpatient					4 LI NU		me 5 Resid				)	
uc		ion	27. Man r of Death 1 Natural 5 Pendi	ng (N	ate of Injury Month, Day Y	Year) 28b.	. Time o	M   28	Bc. Injury Work	at ? ′es 2.∐.l		28d. Describe I	now injui	ry occurre	d		
Division	i or Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could	mined 206. Pl	ace of Injury	/ - At home,	farm, str			03 20	-	28f. Location (5	Street an	nd Numbe	r or Rurai	Route Number	,
Ö	i i i i i	erti	4  Homicide determ	bı	uilding, etc.	(Specify)		,				City or Tov	vn, State	9)			
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (	29a. Certifier 1 Certifyi (Check only one)	ng Physician: To	the best of e	xamination a	ge, deat and/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and man place, ar	ner as stand due to	ated. the cause(s)	
	o the	Mec	29b. Signature and title of certific		Talliel State			29c.	License	number			29d. Da	te signed	(Month, L	Day, Year)	
	->-0		► Wallanto	- Ohol	100	M	Vh.		O C	МЕ			MA	Y 16,	200	4	
	N		30. Name and address of person	who completed o	ause of dea		,										
_			MARYARITO		RELL				111 1	Penn	Stre	et, Bal	Ltim	ore,	Mary	land 21	L201
	Sta		31. Date filed (Month, Day, Year		2. Registrar	s Signature	1	oaks	1.								
	Regist	ar	MAY 2 4 200	4 00	-		14	viens									

Physici		Aegistrar  1. Decedent's Name (First, Middle, L	ast)		2. Date of Death		3. Time of Death
/3/1 e e i i		Helen Mcl	Kee Kolait	is	Month May	Day Year 2004	10:25 A
Medio xamir		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	1 - 2 - 2 - 2
		Potomac Valley N	ırsing Center	Rockville		Montgom	nery
eral tor		<u>578-38-1165</u>	Sex 7. Age (In yrs. last b. 1 ☐ M 2 ☑ F 90	rthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birth Cou	place (State or Forei ntry) (Unknown)
		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	m or Location			10d. Inside City Limit
other treumatic event, the waytest Examines at	ector	Maryland Montgo	nery	Rockville			1 ☐ Yes 2 🔯 N
	I Dir	10e. Street and Number 1235 Potomac Va	lley Rd.	10f. Zip Code 20850	10g.	Citizen of What Cou. United St	
	nerg	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - Ameri Black, White,	
	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced		1 ☐ Yes 2 ☒ No Specify:	no moan, etc.,		White
	pleted	15. Decedent's (Specify only highest g	Education 168 rade completed) College (1-4or 5+)	i. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 16I	b. Kind of Business/In	dustry
	ĕ	Elonomary/Document (5 12)	2	Homemaker		Own Hon	ne
	To Be C	17. Father's Name (First, Middle, Las George Mc	st) Kee	18. Mother's Na (Unkno	ime <i>(First, Middle, Mai</i> WN)	iden Surname)	
OUCE.		19a. Informant's Name/Relationship Donald Wright /		p. Mailing Address (Street and Number or A			Code)
		20a. Method of Disposition	20b. Place	of Disposition (Name of ery, crematory or other place)	Date 200	c. Location - City or To	own, State
		1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Chesa	peake Crematory 200		Beltsvil:	le, MD
		21. Signature of Funeral Service Lic	/	22. Name and Address of Facility Rapp Funeral and ( 9 933 Gist Ave., Si	Cremation S	Services 3. MD 209	10
		23a, Part1. En er the disease, or co	mplications that caused the death. Do	not enter the mode of dying, such as cardia			Approximate
		shock, or heart failure. List on Immediate Cause (Final					Interval Between Onset and Death
n al		disease or condition resulting in death)	Advanced Det  Due to (or as a consequence				
r			Parkinson's	·			
1	ner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):		1	
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. As iration Due to (or as a consequence				<u> </u>
	dicai		d				
	lan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
	ysic	9 Unknown			23e. Did tobac	co use contribute to t	he sever of death?
	y Physician/Medi		contributing to death but not resulting	in the underlying cause given in Part I.	200. 2.4 (0240		ne cause of death?
	þ		contributing to death but not resulting	in the underlying cause given in Part I.		2 No 3 □ Proi	
	þ		contributing to death but not resulting	in the underlying cause given in Part I.	1 Tes  24a. Was an autopsy performed	24b. Were auto prior to co	ppsy findings availab
	Completed by	Part II. Other significant conditions 25. Was case referred to medical	contributing to death but not resulting		1 Tes  24a. Was an autopsy performed	24b. Were auto	ppsy findings availab
	Be Completed by	Part II. Other significant conditions	Hospital: 1   Inpatient 2   ER/O	26. Place of De	1 ☐ Yes  24a. Was an autopsy performer 1 ☐ Yes 2 ∑	24b. Were autoprior to codeath?	pably 4 □Unknown  opsy findings available  mpletion of cause of  2□ No
	To Be Completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 □ Pending investigate	Hospital: 1 Inpatient 2 ER/O 28a. Date of Injury (Month, Day Year) 28b.	26. Place of De	1 Yes  24a. Was an autopsy performer 1 Yes 2 x	24b. Were autoprior to codeath? No 1 Yes  e 6 Other (Specia	post findings available impletion of cause of
	To Be Completed by	Part II. Other significant conditions  25. Was case referred to medical examiner?  1 □ Yes 2 No  27. Manner of Death  1 X Natural 5 □ Pending	Hospital: 1 Inpatient 2 EP/O  28a. Date of Injury (Month, Day Year)  28b.	26. Place of De utpatient 3 □ DOA Other: 4 ☑ Nursing Time of Injury M	24a. Was an autopsy performed 1 Yes 2 The state (Check only one)  Home 5 Residence 28d. Describe how	24b. Were autroprior to condeath? No 1   Yes  e 6   Other (Special injury occurred)	popping 4 Unknown opsy findings available impletion of cause of 2 No
ל אוסטוס הם מפושכוופל	Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigat  3 Suicide 6 Could not determine  2 Accident determine	Hospital: 1 Inpatient 2 EP/O  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, to building, etc. (Specify)  Physician: To the best of my knowledge.	26. Place of De utpatient 3 □ DOA Other: 4 ☑ Nursing Time of Injury M	24a. Was an autopsy performed.  1  Yes 2    25    28d. (Check only one)  Home 5  Residence 28d. Describe how  28f. Location (Stree City or Town, Stree, and due to the cause)	24b. Were autroprior to condeath? 1 No	poppy findings availably impletion of cause of 2 No No Number, all Route Number,
	To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine  29a. Certifier 1 Certifying I (Check only 2 Medical Ex	Hospital: 1 Inpatient 2 ER/O  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, I building, etc. (Specify)  Physician: To the best of my knowled; aminer: On the basis of examination a and manner stated.	26. Place of De utpatient 3 DOA Other: 4 Nursing Time of Injury Mork?  M 1 Yes 2 No arm, street, factory, office  19. death occurred at the time, date and place and/or investigation, in my opinion, death occurred at License number	24a. Was an autopsy performed.  24a. Was an autopsy performed.  1 Yes 2 Stath (Check only one)  Home 5 Residence.  28d. Describe how.  28f. Location (Stree City or Town, Step, and due to the causurred at the time, date.	24b. Were autroprior to condeath? 1 No	popply 4 Unknown  popsy findings available  popsy findings available  popsy findings available  popsy findings available  popsy findings  available  popsy f
completely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine  29a. Certifier 1 Coertifying (Check only 2 Medical Example)  29b. Signature and title of certifier	Hospital: 1 Inpatient 2 ER/O  28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home, to building, etc. (Specify)  Physician: To the best of my knowledgaminer: On the basis of examination a	26. Place of De other: 4 Nursing Time of Injury M 28c. Injury at Work? 1 Yes 2 No arm, street, factory, office  10, death occurred at the time, date and place and/or investigation, in my opinion, death occurred at the time.	24a. Was an autopsy performed.  24a. Was an autopsy performed.  1 Yes 2 Stath (Check only one)  Home 5 Residence.  28d. Describe how.  28f. Location (Stree City or Town, Step, and due to the causurred at the time, date.	24b. Were autroprior to condeath? 1 No 1 Yes  e 6 Other (Special Injury occurred Injury occurred Interest and Number or Runstate)  e(s) and manner as sand place, and due to	popphy 4 Unknown opsy findings available impletion of cause of 2 No No No No No No No No No No No No No

		1	For Stata Registrar	State of Maryland /	Department of Certificate			iene <sub>eg. No.</sub> 2014	16515
			Decedent's Name (First, Middle, La.	st)			2. Date of Deat Month		3. Time of Death
	Physicia	_	RANDOLPH LOG	AN JR			05-14	- 2004	3:30 AM
>	/Medic Examin		4a. Facility Name (If not institution, giv			vn, or Location of Death		4c. County of Deat	n
			LORIEN FRANKF		1	LTIMORE	Talla (and	NA	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last	birthday) If Under 1 \ Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry) VA
	Director	-	230 · 36 · 6361		113.		06.04	. (900)	1071
	land ow		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Mary	ō	MD NA	HARL	EM				1 No 2 No
	h the	Director	10e. Street and Number		10f. Zip Co		1	10g. Citizen of What Co	untry?
	th wit	aiD	3606 VICTORIA	BLVD.		3661		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceden If Yes, specify	t of Hispanic Origin? (S) Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖄 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🖟	No Specify:		Specify: B1	ACK
21215-0036	72 hours after death with the Maryland naturel; or Items 23s or 28s-1 show ites! Esabited must to multifud at	edt	15, Decedent's E	ducation 1	6a. Decedent's Usual C	occupation		16b. Kind of Business/	
15	c = Q	plet	(Specify only highest gri	ade completed)  College (1-4or 5+)	life. DO NOT use i			10 000-	DCOLCK-
212	filed with Hygiene. thar ther	Completed	9 TH GRADE	NA	POSTAL	CLERK		us post	OFFICE
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yla	should be filed within and Mental Hygiene.  marked othar then umatic evant, Ire M	၉	RANDOLPH LOGA	IN , 5R.	19b. Mailing Address (5	hand Market or Co	m / Courte Numbe	c City of Tour State	Zin Codel 1101K
Maryland	2 sho	0 10	19a. Informant's Name/Relationship	Type, Print) WNK	19b. Mailing Address (5	treet and Number or Hu	rai Houte Numbe.	r, City or Town, State, 2	ip code) var-
	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 la marke any injury or other traumatic once.		20a. Method of Disposition	20b. Place	e of Disposition (Name	of .	Date UNK	20c. Location - City or	Town, State
آو	Pages nent of nut: If It ury or o		1  Burial 2  Cremation 3 '4  Donation 5  Other (Special	Removal from State	etery, crematory or othe E CHAPEL BI		1	LANCASTER	VA
Baltimore,	permit. Pag Department Importent: I any injury o	li	21. Signature of Funda Service Lice			Address of Facility GREENE FU			ERRY WADDY)
Ba	permit. Departr Import any inj		Daniel (		5151 BALTO	· NATL PIKE	BALTO.	MO. 21229	
			23a. Part1. Enter the disease, or con shock, or heart ailure. List only	pplications that caused the death. I	Do not enter the mode	of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Autoumm	Dr.	sea ?	Sundra	mi	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequen	nce of):		11		
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	deat he att	sick	in the past 12 months?	4 Pregnant at time of deat 9 Unknown				WOM	ou, rou
P.0.	requires that the death een signed by the atter nould be detached for u	Phy	9 Unknown  Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cau	sa giyan in Part I	23e. Did to	obacco use contribute to	the cause of death?
S,	ires the signer of the d	by	Part II. Other significant conditions	COMMISSION OF THE POLICE POLICE	ng m mo andonyng dad	<b>5 9 1 1 1 1 1 1 1 1 1 1</b>	1 🗆 Y	res 2□No 3□P	robably 4 Tunknown
0.00		Completed					24a, Was	an 24b. Were a	utopsy findings available
Rec	e la has	mp					autop	rmed? death?	utopsy findings available completion of cause of
ja	iclan: Th certificate ector, pag	e Co	25. Was case referred to medical			26. Place of De	1 ☐ Yes ath (Check only o		5 2 NO
>		0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 DOA	Other: 4 Nursing	lome 5 ☐ Resid	dence 6 □Other (Spe	ocify)
to		n: T	27. Manner of Death 1. ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of 280 Injury	: Injury at Work?	28d. Describe h	now injury occurred	
io	Attending or death. actor: After by the fune	atic	2 Accident investigati	on	М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not determine		e, farm, street, factory,	office	City or Tov	Street and Number or R vn, State)	urai Houte Number,
	Hospitel of thours at Funaral D	Ce	Son Continue of Tableson I	Physician: To the best of my knowle	adae death accurad at	the time, date and place	and due to the	cause(s) and manner a	s stated
	Hose 24 ho Funs	edical	29a. Certifier 1 Certifying F (Check only 2 Medical Ex-	aminer: On the basis of examination and manner stated.	n and/or investigation, i	my opinion, death occi	irred at the time,	date and place, and du	e to the cause(s)
	To the Hospitel or Attend within 24 hours after death To tha Funaral Diractor: completely filled in by the	Med	29b. Signature and title of certifier		29c.	License number		29d. Date signed (Mon	
	E>E0		> all	Azv		D 31464		5(17(0)	7
	Q		30. Name and address of person wh	o completed cause of death (Item 2	23a) (Type, Print)	0		1 2 11	
_			SHOAIIS A 4	ASHMI \$21	N. Entan	of the	100 JOC	isalt.	M1) 21201
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re 4 1				
	Regist	rar	MAY 2 4 2	UU4 Birdina	D 100	K			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2004 **Physician** May 16, 12:53P™ William Bartholomew Lombardi, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilcrest Hospice of Baltimore N/A Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 5. Social Security Number 6. Sex Days Hours Min. **Funeral** Months 1 □ M 2 □ F 015-03-7170 86 August 15, 1917 MASS. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County r then "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4300 Leeds Ave. 21229 U. S. A. filed within 72 hours after death Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status TYPes 2□No 1944-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 1946 Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Deputy Manager Manufacturing is marked other other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Angelina Bertolini Pietro Lombardi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu 21229 Baltimore, MD. Judy Lombardi, wife 4300 Leeds Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 05-20-04 Elkridge, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -Iver bulure weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Army loidosis Sequentially list conditions, if any, leading to immediate Lombardi, William Due to (or as a consequence of): Examine plasma cell dyscrasit burial-transil Cause (Disease or injury that initiated avents signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 DEctopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No this certificate 1 🗌 Yes 2/21No of Vital 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 1 🔲 Yes 2 ER/Outpatient 3 DOA P 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death Injury at Work? Director: After 1 Natural 2 Accident Division Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funerel [ To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical [2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number

\$\int \frac{5}{3} \frac{3}{3} \tag{3}\$ 29d. Date signed (Month, Day, Year) e and address of person who completed cause of death (Item 23a) (Type Print) harles St Baltunone MD 21204 6601 32. Registrar's Signatu State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 Danny Joe Lilly May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 8 Southfield Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, ) August 1/ 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Beckley, WA 1 M 2 □ F 61 Yrs. 232-64-4371 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be titled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 ie marked other then "natural", or Items 23e or 28e-f ehow ury or other traumatic event, the Madical Extratural must be notified at 10c. City, Town or Location 10b. County 10a. State il Hygiene. I chier then "natural", or items 23e or 28e-f ehow vent, the Medical Exerciter must be notified at 1 TYes 2 No Glen Burnie Anne Arundel Maryland Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 USA 8 Southfield Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Warried White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethleham Steel Fire Fighter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Wiles Hobert Lilly 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 Southfield Road, Glen Burnie, MD 21060 Leslie L. Lilly 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition P.O. Box 2966 Metro Crematory, Inc. May 22, 2004 Baltimore, MD 2122 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Se vice Cio-nsee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or comshock, or heart failure. List only or comp Immediate Cause (Final 2027 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine after death.

Director: After this certificate has been signed by the attending physician and the type the tuneral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2 The law requires that the death certificate be executed 0 Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 28d. Scribe how injury occurred 28b. Time of 28c. Injury at Work? Manner of Jeath 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2106 AGA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For Amend Item #7 per	State of Me	724704 (J	Depar	tment o	of Hea	alth a	nd M	ental Hy	giene	201	) [ <sub>4</sub>	165
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/Medic	cal			Cur III						Ma			004	4:451
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		Johns Hopkin					alti							
Funeral		5. Social Security Number 6. Sex	7. Age	e (In yrs. last bi	,	If Under 1 \		Under 2 lours	4 Hrs.	8. Date of Bir (Month, Da	ay, Year)		Birthple Counti	ce (State or For
Director		214-69-7523	7 201		Yrs.	6 7	5 7			Nov 1	8, 20	03	VA	
2		Usual Residence of Decedent		40 - O't - T									Т	
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he F	edi	one)	and manner sta	ted.	TIQUOI IIIVOS	sugation, in	my opinio	m, death	OCCUITE	odat the time,	date and	piace, and	due to ti	ne cause(s)
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		30. Name and address of person who com	pleted cause of de	eath (Item 23a)	(Type, Pri	int)		-	7	1	0 1		10	2069 .ospita
		Sharon L.	e Ma	- 10a. U	1/	(,4).			70	nus	robi	ring	5 17	Daper
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DHMH 17 Rev 1/2001

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		•	For State Registrar	State of I	Marylan	•	artmen rtificat			and M		Reg. No 20	04	16519
	Physicia	an	Decedent's Name (First, Middle, Las     Rubv     Jul		Mabe						2. Date of De. Month Ma y	Day 22	ž004	3. Time of Death 10:35 AM
,	/Medic Examin	al	Ruby Jui				4b. City.	Town, or	Location of	of Death	ria y	4c. County		10.33 A
	Examin	er	21 Winding Woods		·				dena			Anne	e Arur	ndel
ı	Funeral Director		220-30-0731	ex 7. □M 2⊠F	Age (In yrs. I	ast birthday) 71 Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bird Month, Da JUNE 2	**************************************	9. Birthpi Coun	ace (State or Foreign try) VA
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation						10	Od. Inside City Limits
	Mary	tor	Maryland Anne	Arundel				Pa	sader	na				1 ☐ Yes 2 ☒ No
	n 72 hours after death with the Maryland "naturel", or Items 23s or 28s-f show edical Examiner must be ricitified at	Funeral Director	10e. Street and Number	May			10f. Zip	Code	24420	)		10g. Citizen of	What Coun	try?
	eath v	erai	21 Winding Wooda	Wd y 12. Was Decede	ent Ever in U	S 13	Was Dece	dent of H	21122		ecify Yes or No	- 14. Rac	e - Americ	an Indian.
٥	after d	Fun	1 ☐ Never Married 2 ☒ Married	Armed Force	es?					, Puerto	ecify Yes or No Rican, etc.)	Bla	ck, White,	
25	urel', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		1 🗆 Yes		Specify:			Specif	·	
9500-512	n 72 t	Completed	15. Decedent's Ec (Specify only highest gra	de completed)		16a. Dece (Give life.	dent's Usua kind of wo DO NOT u	al Occupi ink done d se retired	ation <i>Juring m</i> os I)	t of work	ing	16b. Kind of B	usiness/Ind	dustry
717	filed within 72 Hygiene. ther than "nat	mo:	Elementary/Secondary (0-12)	College (1-4	or 5+)			emble				Mar	nufact	turing
2	be file tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)									Maiden Sumar	ne)	
Maryland	D & 0 0	ို	Claude Re	edy		10h Maili	na Address	(Street		ıla xor <i>Bu</i> z		ite er, City or Town,	State Zin	Code)
<u>8</u>	ges 1 and 2 shoul nt of Health and M if itam 27 is mar or other treumati		Curtis Mabe	(Spo	use)		3.0					ena, MD		
e,	es 1 a of Hea f itam r othe		20a. Method of Disposition  1 XBurial 2 Cremation 3		20b. P	lace of Dispo emetery, cre	sition (Na	me of			25	20c. Location		
altimore,	Pages iment of I tent: If its jury or o		`4 □ Donation 5 □ Other (Specify	y)	G1	en Hav			er y	2(	004	Glen Bu	ırnie.	, Maryland
Rai	permit. Pag Department Importent: f any injury o once.		21. Signature of Funeral Service Vicer	isee )		2	2. Name ar 3111			•		ngs Fune dena, Mi		Home, P.A.
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cau	used the death th line.	n. Do not en								Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition	~ NO2		lodg	km	15		ym	pho	ma		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):()				U				0
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	uence of):			<u> </u>			· · · · · · · · · · · · · · · · · · ·		
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	death certificate be executed e attending physician and of for use as the burial-transit	icai Ex	resenting in death) cast	Due to (or	ras a consequ	uence ot):								
68	tificate ig phys as the			. a										
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgptrs?		h 2 Feta	death 3	⊒Ectopic p	regnancy	,				ite of delive	ny Day Year
0.		Physician/Med	1 Yes 2 No	4□Pregnar 9□ Unknow	nt at time of d	eath 5[	Other (s <sub>f</sub>	oecify)						ouy rou
S, P.	as the	by	Part II. Dther significant conditions of	ontributing to dea	th but not res	ulting in the u	underlying o	cause giv	en in Part I	l.		obacco use con		ne cause of death?
Records,	w require been sig should b	eted									24a. Was			psy findings available
	The lay	Completed									auto	psy ormed?	prior to cor death?	npletion of cause of
ita	ysicien: The is certificate hidrector, page	BeC	25. Was case referred to medical examiner?							e of Deat	n (Check only			
5	문 등 E	.T	1 Yes 2 No	Hospital: 1 Inp		ER/Outpatie			4 🗆 NI	ursing Ho		dence 6 Ott		/)
O	Attending For death.	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,	Day Year)	Injury	м	28c. Injur Wor 1 □	k? Yes 2□	No		,,		
Division of Vital		Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place o	f Injury - At ho g, etc. (Specif	ome, farm, st	reet, factor	y, office			28f. Location ( City or To		ber or Rura	l Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C		nysicien: To the b	is of examina									
	To the within i	Mec	29b. Signature and title of certifier	and manne	n stated.		29	c. Licens	e number			29d. Date signe	ed (Month,	Day, Year)
)	->		Man	-a-1	1,0			D3	95	05		may	24,	2004
	Y		30. Name and address of person who	completed cause	of death (Iten		Print)	al .	Di	~	Colone	may sum	10	MD
	Sta	ate	31. Date filed (Month, Day, Year)	Les .	gistrar's Signa		OSPIF		27		year 1	300 000	,	21061
	Regist		MAY 2 4 2004		, K	Great								

	1- State of Maryland / Dep. Registrar  Ce	artment of Health and Martificate of Death	Reg. f	0001	16520
Physician	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death U
/Medical	THE PARTY OF THE P	4b. City, Town, or Location of Death	MAY 19	2004 4c. County of Deeth	3:20 F M
Examiner	NATIONAL NAVAL MEDICAL CENTER	BETHESDA		MONTGO	MERY
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea May 20, 19	9. Birtho Cour 958 Mass	elece (State or Foreign achusetts
2	Usual Residence of Decedent				0d. Inside City Limits
7/2 hours after death with the Maryland neture!', or Items 23s or 28s-1 show local Evants or neat be notified at steed by Funeral Director	Maryland Anne Arundel Glen Bu				1 ☐ Yes 2 No
or 28e enoti	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cour	ntry?
23a c	743 Nabbs Creek Road	21060		USA	and Indian
To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecity Yes of No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
"netura "netura adical E	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	. Kind of Business/In	dustry
ed within 72 hot ygjene. ner then "neture it, the wed call Completed	Elementary/Secondary (0-12) College (1-4or 5+) HOING	emaker		Household	***-
Mental Hy arked oth attic even	17. Fathers Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid Shirley	Grandvill	le
th and M	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address <i>(Street and Number or Rur</i> Nabbs Creek Road,			
ages I an ent of Heal nt: If item 2 ry or other	20a. Method of Disposition  1 Burial 2 Decremation 3 Removal from State  4 Donation 5 Other (Specify)	esition (Name of matory or other place) ematory, Inc. May	20c. 22,2004 Ba	Location - City or To 0. Box 29 Itimore,	own, State 66 MD 21229
permit. Page Department of Importent: If eny injury or once.	21. Signatur of Funeral Service Licensee		a]]ings Fu	neral Hom	e, P.A.
Physician	23a. Part 1. Enter the disease, or comblications hat caused the death. Do not en shook, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac  Y ARTERY DISEASE	or respiratory arrest,	1, 110 2112	Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death)  Due to (or as a consequence of):				
executed on and rial-transit  Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
ysicie	Due to (or as a consequence of):				
eath certificate attending phy for use as the	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	∃Ectopic pregnancy		23d. Date of deliver	ery Day Year
hat the death certion by the attending stateched for use a Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Winknown  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Other (specify)		World	Day Tou.
es t gne be d	Tarris Dillo digital da di la	inderlying cause given in Part I.		co use contribute to t 2 No 3 Prot	he cause of death?  pably 4 Munknown
stcian: the law require tector, page 2 should be Signed by Special			24a. Was an autopsy performed 1 ☐ Yes 2 📉	? death?	ppsy findings available mpletion of cause of
Physician: ral director, pra To Be C	25. Was case referred to medical		th Check onl one		
\$ # P F	1 ☐ Yes 2 🛣 No Hospital: 1 🔀 Inpatient 2 ☐ ER/Outpatie				(y)
fte ng	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
itel or Attending P is after death. el Director: After t led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Location (Street City or Town, St		al Route Number,
Hosp 4 hou Fune tely fil	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
To the within 2 To the comple	29b. Signature and tith. I certifier	29c. License number ME 74432 (FL)		Date signed (Month,	
5	30. Name and address of person who completed cause of the filler 23a) (Type			-	2004_
	MICHAEL A. ILLOWSKY CDR MC USN  31. Date filed (Month, Day, Year)  32. Registrar's Signature	BETHESDA M	D 20889-56	600	
State Registrar		les			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20 Day **Physician** 2004 11:34 p M May /Medical County of Deeth 4b City, Town, or Location of Death Examiner last birthday) **Funeral** Days Director 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location ral', or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? Completed by Funeral death Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Yes, Give Year or Dates: 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
ifte. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Macical College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle, Last) Be (UNKNOWN) Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or of Burial 2 Cremation 3 Removal from State JWIMS (Y), ILS 4 □Donation 5 □ Other (Specify) Vaughn Greens Funoral Srics. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or hear-failure. List only one cause on each line. Approximate Interval Between Onset and Death Infarction 20 to Immediate Cause (Final disease or condition resulting in death) yocardial Physician hersclerotic Disease /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physician P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Cinknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 1 Yes 2 No the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar PETER PRENTICE

31. Date MAY 27, 47, 2004

DHMH 17 Rev 1/2001

JESSE MASSEY

BX 527

LEONARDTOWN MD

20650

ess of person who completed cause of death (Item 23a) (Type, Print)

MARYS HOSPITAL 32. Registrar's Signature

ST.

Securing 1  Securi	Physicia	an	1. Decedent's Name (First, Middle, La	•				2. Date of Month	1000	Yeer 3. Time o		
Social Hot of the Comment of the Com	/Medic	al										
Social Security Number   20	Examin	er	_	1 0 0 .	1,000	-		b. /	4c. County	of Death		
Dead Residence of Deadert   Dead Residence of Deadert   Deader Residence of Deadert   Deader Residence of Deadert   Deader Residence of Deadert   Deader Residence of Deadert   Deader Residence of Deadert   Deadert R	Funeral					If Under 1			Birth	9. Birtholace (State of		
The part of the			210 09 2300			Months [	Days Hours	Min. Mar 2:	Day, Year) 3, 1916	New Jerse		
1.1 Bural 2   Consider   Specify   State   Anatomy Board   Specify   State   Specify   State   Specify	M =			10c. (	City, Town or Lo	ocation				10d, Inside C		
La Burral 2   Coremands   Classes of Facility   State Anatomy Board   State   Approximate   State	e-f sho	ctor	MD Baltim	ore	Randa	11stow	n			1 🗆 Yes		
1.1 Bural 2   Consider   Specify   State   Anatomy Board   Specify   State   Specify   State   Specify	a or 28 De no	Dire		4		10f. Zip Co				•		
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Security   Control of Security   Security	F. Kan	þ	3 Nidowed 4 Divorced	If Yes, Give		1□Yes 2X	No Specify:		Specify	white		
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Complete the disease of complete to make the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval to sease of conditions contributing to death but not resulting in the underlying cause given in Part I.    Contribute of the death	othe vent.							's Name (First, Midd				
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Complete to the disease, or Complete to the death of the control	em 27							The second secon	-			
Sequentially list conditions.  If FEMALE:  23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals a consequence of):  Use to (or as a consequence o	2 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer	natory or othe	r place)	Date	20c. Location -	City or Town, State		
Sa Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval a check of heart failure. List only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is only one cause on each line. It is one to line as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, a day, each of index or index or resulting in death) Last  Due to (or as a consequence of):   Departm Importar any inju		21. Signatura of Funeral Service Licer	see //	or Si	tate Ar	iatomy Bo	pard 655 W	J. Baltim	ore Street			
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Due to (or as a consequence of):    Continue	vsician		Immediate Cause (Final	one cause on each line.						Interval Bet Onset and I		
Sequentially its conditions.    Sequentially its conditions as a consequence of):	Medical		resulting in death)	a	equence of):			11		T da		
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   Xey 0		_	Sequentially list conditions,	0.		of feel	e Ent	egopolitis		+ we		
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   Xes   Yes	nsit	nine	di any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2 1 1	9 4	- 4-100	a /	1/41				
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the conditions of the contribution of the cause of the conditions of the condi	ling ph e as th	Med	IF FEMALE:									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the completion of death autopsy performed? It was an autopsy performed? It was a performed? It was	attend for us	lan/	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet	tai déath 3□				· ·			
23e. Did tobacco use contribute to the cause of the course	y the	ysic					Other (specify)			Month Day		
24a. Was an autopsy finding prior to completion of death?  25. Was case referred to medical examiner?  1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    26. Place of Death Check only one)  27. Manner of Death  1   Natural      ned by e deta		Part II. Other significant conditions c	ontributing to death but not re	sulting in the ur	nderlying caus	e given in Part I.	23e. Did	I tobacco use contr	ibute to the cause of d			
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25. Was case referred to medical examiner?  1	as bei	plet								Vere autopsy findings a		
25. Was case referred to medical examiner?  1	page	Com						per	formed?	leath?		
1   2   2   No   No   No   No   No   No	ector	Be		Liagnitals				of Death Check only	one)			
2 SAccident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	sidii dii		71	1 Inpatient 2L		the state of the s	4 Nurs					
29a. Certifier (Check only one)  29a. Certifier (Sheek only one)  29b. Signature and title of certifier  29c. License number  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	: Afte	tion	1 ☐ Natural 5 ☐ Pending		Injury	M	Work?		~ D.	90		
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29a. Certifier (Cheek only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	el Dir	Cert	4   Notificide	rehel	old talein	Face	7,4	0.1, 0, ,	om, olalo,			
	e Funer letely fill		(Check only 2 Medical Exam	iner: On the basis of examin	nowledge, death nation and/or inv	occurred at the	he time, date and my opinion, death	place, and due to the	e cause(s) and mar	nner as stated .		
	To the	Me	29b. Signature and title of certifier			29c. Lie	cense number		29d. Date signed	(Month, Day, Year)		
			M				RES C	200	April	1,200		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mork Clora  5, 5, 6				completed cause of death (Ite	_	1144				. ,		

Frederick J. O'Brien, Jr. 04-03406 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. cm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Fredrick John O'Brien, Jr. /Medical 20 2004 10:11 May 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | May 21, 1964 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1XM 20F 39 Yrs. Director 495-80-3526 Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. ral', or items 23a or 28a-f ebov Examinar must be notified at Director Maryland Frederick 1 Yes 2 No Frederick 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6657 South Clifton Road 21703 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes XX No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed the Mudicul 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail Building Supply 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fand Mental M Is marked Fredrick J. O'Brien, Sr. Frances <u>C.</u> Gross 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ai
Important: If Item 27 Is
any injury or other traus Robert Bucher - Father In Law 1607 29th Street St. Joseph, Missouri 64506 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet '4 ☐ Donation 5 ☐ Other (Specify) 5/27/04 Kansas City, Missouri 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home At MMP., 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician lurie3 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed the burial-transit and Due to (or as a consequence of): physicien Physician/Medical as 1 esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) o. detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 3 Probably Completed 1 ☐ Yes 2 ☐ No 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an has page autopsy performed certificate 1X Yes Yes of Vital 2 ☐ No Physicien: 25. Was case referred to medical examiner?
1. Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 this After thi funeral of 28d. Describe how injury occurred
DIVER OF COS. N.
(N. COLLISION) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Attending 5 Pending Natural Injury 0656 5-2004 death. investigation 2 Accident 1 Yes Director: 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) ROULE 355 and Bennett efter 4 Thomicide ö To the Hospital c within 24 hours of To the Funeral D completely filled in Creek Road, Ijansville, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 21, 2004 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD111 Penn Street, Baltimore, Maryland 21201 POLIAK 32. Registrar's Sidoature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:55 **Physician** 2004 Mau Henry Andrew Pfarr /Medical 4c. County of Deeth Bal HM ON 4b. City, Town, or Location of Death give street and number) 4a. Facility Name (If not institution, Examiner Franklin Square HMOVE Rosed MOSPUTA If Unde If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Se **Funeral** Days Hours 1 △ M 2 □ F 66 19,1938 Maryland March Director 214-14-3961 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State rithen "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Carroll Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 1126 South Main St. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ⊇ No If Yes, Give Year or Dates: Unknown 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 IDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) 2<sup>Cotlege (1-4or 5+)</sup> I Hygiene. Elementary/Secondary (0-12) Iron Worker permit. Pages 1 and 2 should be itied with Department of Health and Mental Hygien Important: if item 21 is marked other the any injury or other traumain Iron Fabrication 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Myrtle Schleru 2 Henry Pfarr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1126 South Main St. Hampstead, Maryland 21074 Anna R. Tusing/ Fiancee 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐Cremation 3 ☐Removal from State Baltimore, Maryland Bayview Crematory 5/24/2004 `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Se 1328 Sulphur Spring Rd. Arbutus, Maryland 21227 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final Metastatic 1car **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Pol in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) Yes 2 No P.O. detached 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, COP 1 Ves 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has breaking to be selector, page 2 s autopsy 2 No 2 No 1 Tyes 1 Yes 26. Place of Death Check on one Be 25. Was case referred to medical Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☑ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA funeral dir this 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 A Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigetion 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospitel 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ro the 29c. License number 29d. Date signed:(Month, Dev. Year) 29b. Signature and title of certifier 00056851 2004 (r 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive Bacto, Md 9000 THOMAS 32. Registrar's Signature 31. Date filed (Month, 2 4 2004 State Registrar

			1 _ For	State of Mary	land /				Mental	Hygien		16525
			Registrar			Certific	cate of l	Death	2 Date	Reg. No	.2004	3. Time of Death
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7	/Medic Examin	-	4a. Facility Name (If not institution, give		ME		City, Town, or	Location of De			C. County of Death	1000
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	and		Usual Residence of Decedent  10a. State 10b. County	10	c. City, To	own or Location						10d. Inside City Limits
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36	rs efte	by Funeral Director	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □ Y	es 2 No	Specify:			Specify: 2	0.012
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pu	be fill htai H od oth	Be	17. Father's Name (First, Middle, Last)	<i>C</i> *				18. Mother's N		_		
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Вох	death certifica attending pt d for use as t	ian/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal dea		oic pregnancy	•			23d. Date of deliver Month	very Day Year
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<u>α</u>	The law requires thet the death sie has been signed by the atter bage 2 should be detached for u		Part II. Other significant conditions cor	ntributing to death but no	ot resulting	g in the underly	ing cause give	en in Part I.	23e	. Did tobacco	use contribute to	the cause of death?
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Division	l or Attendater deati	Certification;	4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)	, tam, street, ta	ictory, office		City	or Town, Sta	and Number or Rui te)	al Houte Number,
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	n 24 t	edical	(Check only 2 Medical Exami	ner: On the basis of exa and manner stated	amination	and/or investig	ation, in my o	pinion, death oc	curred at the	time, date ar	nd place, and due	to the cause(s)
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			Stephen	11. 7	=	m-0	D45	1658	•	MA	1418, 2	2004
	7		30. Name and address of person who co	ompleted cause of death	1 (Item 23	a) (Type, Print)		1	21.00	Bas	1418, Z	2/770
			31 Date liled Manual Day Mean	32/Registrar's			OCIT /	AVEN S	VLVD	WITH	עווןיט	1257
	Sta Registr		31. Date liled WAY 27.4 2004	Serve	July Ialui 6	5 d	Day of	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 20, **Physician** William Floyd Pelham 2004 2:15 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center Towson If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 📈 2 🗆 F Yrs. 79 OCT 4, 1924 New York Director 077-18-1954 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examinatinust be notified at 1 XYes 2 No N/A Baltimore Director Maryland 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21218 3900 N. Charles Street #1216 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. TYes 2 □ No f Yes, Give Year or Dates: 1 Never Married 2 Married 944ŏ 1 ☐ Yes 2√ No Specify: White Completed by 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) 5 + Elementary/Secondary (0-12) Professor College should be fin th and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( Margaret Giffith Floyd Pelham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 l 21218 Marilyn Pelham/Wife 3900 N. Charles Street #1216 Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial Cremation 3 Removal from State Department of Important: If it any injury or conce. 5-20-04 Metro Crematory Inc. Baltimore, MD 21. Signature of Funeral Service, Licensee
Thomas Gregor Cremation Society of MD, Inc. 299 Frederick Road <u>Baltimore, MD</u> 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 months Bladdes Physician netastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Atox 1 Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Hyperten 31 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ✓ No ို this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Tes 2 No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Hospital or Attanding Physician: Director: within 24 hours a To the Funeral D

Registrar DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 639 N. Charles McConnell

31. Date filed (Month, Day, Year)

29a. Certifier (Check only one)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3:05 P. M **Physician** 2004 James G. Reed, Sr man /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner North Arundel Hospital Glen Burine Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 5. Social Security Number **Funeral** Days 12 M 2 ☐ F 85 Yrs. 215-07-7465 Feb 10, MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County orent: If item 27 is marked other than "naturel", or items 23s or 28s-1 show injury or other traumatic event, the Maclical Examinar must be notified at 1 ☐ Yes 2 MNo Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 United States 410 A Secluded Post Circle Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ♥Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Item eny injury or other traumatic event, the Market is an once. 1 Neyer Married 2 Married Specify: White 1 Yes 2 No If Yes, Give Year or Dates: 44-46 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Residential Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Reed Harry Susan Unknown 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Paul Reed/Son 4300 Kenwood Ave, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition May 24 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 Beltsville, MD 22. Nama and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Vicensee of pour 8717 Green Pastures Drive Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 1 Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one Be 1 Yes 2 No
27. Magner of Death
Natural Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After or Attending 5 Pending 1 ☐ Yes 2 ☐ No To the Haspital or Attendii within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and ess of person who completed cause of death (Item 23a) (Type, Print) Name and add 31. Date filed (Month, Day, Year) State MAY 2 4 2004 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

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		7	= State Registrar		Certific	ate of Death	2. Date of De	Reg. No.	3. Time of Death
-	Physicia		Decedent's Name (First, Middle, I		1 Ru	-1(	Month	Day	Year , CA 72 Q.
	/Medic	al	JANIE	BASSCH		ity, Town, or Location of	MAY	2.C Z	00 11
	Examin	er	ta. Facility Name (If not institution of		70.		RNIE	Δ	A
				HAIZTEIZ K	last birthday) If Ur	der 1 Year If Under 24		th	Birthplece (State or Foreign
	Funeral Director		424-36-1822	1□M 2☑F	71 Yrs. Mont		Min. (Month, Da May 2	th ay, Year) 2, 1932	Birthplece (State or Foreign Country)     AL
			Usual Residence of Decedent						
шď	ylano		10a. State 10b. County		ty, Town or Location				10d. Inside City Limits
	Mar a-f el	tor	MD Anne	Arundel G	len Burnie				1 ☐ Yes 2 🗹 No
30	th the	Director	10e. Street and Number			Zip Code		10g. Citizen of W	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examitment has notified at 200c.	ai	6504 South Char	ter Rd, Apt. G		21061		United	
(de	ems erra	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Di If Yes,	specify Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	5- 14. Race Black	- American Indian, , White, etc.
90,	or it	y Fu	1 Never Married 2 Married	If Yes, Give	1 □ Ye	s 2 No Specify:		Specify:	White
<b>08</b>	hours urei',	d by	3 Widowed 4 Divorced	Year or Dates:	16a, Decedent's	leval Occupation		16b. Kind of Bus	White
ON	n 72 i	lete	15. Decedent's (Specify only highest	grade completed)	(Give kind o	work done during most of use retired)	of working		d Department
22	withir	Completed	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Clerk			Of Trar	nsportation
<b>2</b> 0	filed Hygid ther ont, I		17. Father's Name (First, Middle, La	ıst)		18. Mother	s Name (First, Middle	, Maiden Sumame	a)
a L	d be antal ced o	o Be	Unknown Baesch	h		Anna	Unknown		
Janie Baesch 5 <b>Baltimore, Maryland 2</b>	2 should be and Mental is marked c	၉	19a. Informant's Name/Relationship	o (Type, Print)	19b. Mailing Add	ress (Street and Number	or Rural Route Numb	er, City or Town, S	State, Zip Code)
<b>Z</b> e ∈	and 2 : ealth ar n 27 is		Walter Ruth/Hus	sband	6504 So	uth Charter	Rd, Apt.	G, Glen	Burnie, MD
യ് മ്	Hea Hea tem other		20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	(Name of or other place)	Date May 24	20c. Location - 0	City or Town, State
<b>9</b> E	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☑ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe	Hemoval from State	hesapeake		2004	Beltsvi	lle, MD
건별	nit. F artme ortar injur		21. Signature of Funeral Service of		22. Nam	e and Address of Facility mation and	Funoral Al	tornation	700
Ja <b>Ba</b>	permit. Departnimports any inju		Stoly AV	umanun Moss		7 Green Pas			more, MD
			23a. Part1. Elter the disease, or co shock, or heart failure. List or	omplications that caused the dea		mode of dying, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between
	Dhysician		Immediate Cause (Final	^	OMA	PANCRE	AS		Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	-	HICKE	7 3		01/00/11
0	Examiner								
	*	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):				
	cuted td ransit	Examiner	triat initiated events	c					
oʻ	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a conse	quence of):				
760,	te be ysicia ne bu	cal		d					
Box 68	that the death certificate ed by the attending phys detached for use as the	Jed	IF FEMALE:						
ŏ	th ce tendii r use	an/h	23b. Was decedent pregnant	23c. If yes, outcome of pregr	tel death 3 Ectop	ic pregnancy		23d. Date Mor	e of delivery oth Day Year
	dea he att	sici	in the past 12 months? 1 🗆 Yes 2 MNo	4 Pregnant at time of 9 Unknown	death 5 ☐ Othe	r (specify)			
P.0	at the	Phy	9 Unknown			in acuse gues in Bod I	23a Did	tobacco use contr	ibute to the cause of death?
S,	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	Completed by Physician/Medi	Part II. Other significant condition	2/1/+/)	I DC T	ing Cause given in raici.			3 ☐ Probably 4 ☑ nknown
ord	een s	ted	01AB2125 112	100	100000	_ <	<del>-</del>		
ပိ	e law i has b	ηpie	L'ORONARY	HRTERY	DISEA-	2	24a. Was	psy p	Vere autopsy findings available into to completion of cause of leath?
		Son	TIC DOLD	REAUX			1 ☐ Yes		Yes 2 No
/ita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hespital		/	of Death (Check only	one)	
7		P	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	1			idence 6 Othe how injury occurre	
2	ing F	on:	27. Manner of Death  1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		now injury occurr	50
Sic	ttendi death. ctor: A y the fu	cat	2 Accident investigated investi	ot be 280 Place of Injunt - At				(Street and Number	er or Rural Route Number,
Division of Vital Records,	after of Direction by	Certification;	4 Homicide determin		cify)	outy, onlo		wn, State)	
الما يري	To the Hospital or Attending Physwithin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di		29a. Certifier Certifying	Physician: To the best of my ki	nowledge death occu	rred at the time, date and	place, and due to the	cause(s) and ma	nner as stated.
1 2	e Hospital 24 hours e Funeref letely filled	edicai	(Check only 2 Medical E	xaminer: On the basis of examination and manner stated.	nation and/or investig	ation, in my opinion, deat	h occurred at the time	, date and place, a	and due to the cause(s)
	To the I	Me	29b. Signature and title of certifier	11		29c. License number		29d. Date signed	d (Month, Dey, Year)
	F ≯ F ŏ		Malan	7 18.	MT	DOZE	19	MAN	212004
	10		30. Name and address of person w	the completed cases of death (It	em 23a) (Type Pfini)	0000		0	21 2004 Be1004
	U		CICHIA RT	FISIN S	17	RAIN TO	WERS	(2681	J DURNIE
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	,			
	Regist		MAY 2 4 21	101 Brewn	19 1	20 15 A			

			ricase Type of Fine in Diack indensity into	Zilodic Ali Cop	IOO AIO E	og.bio.				
			State of Manyland / Department of He State of Manyland / Department of He State Registrer Certificate of D	ealth and Mental	Hygiene	2001	16520			
				calli	Reg. No.	1.004	10025			
£	Physicia /Medic	an	1. Decedent's Neme (First, Middle, Last)  TAVEN WENDY ROBER		of Death h Day L 24	, 2004 1	Time of Death  2:30PM			
	Examin	er	4a. Facility Name (If not institution, give street and number) UNIV: OF MARYLAND MEDICAL SYSTEM BAL	Ocation of Death		County of Death FLTIMORE	CITY			
	Funeral Director		5. Social Security Number  6. Sex THE M 2 X F  7. Age (In yrs. last birthday) If Under 1 Year Months Days 3.19	Hours Min. 8. Date (Mon	of Birth th, Day Year)	9. Birthplace Country) MARYLO	(State or Foreign			
	P _	-	Usual Residence of Decedent			104.1	acida Citat imita			
	a-f ehow	ctor	10a. State  10b. County  10c. City, Town or Location  Ballimore	2			nside City Limits  ☑ Yes 2 ☐ No			
	h with the	ai Director	10e. Street and Number 261/ Canver Rd 21	1225	10g. Citize	en of What Country?	4			
980	J within 72 hours atter death with the Maryland jiene Than "natural", or itema 23e or 28e-f ehow I'm Medical Erain" at must be trelified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	panic Origin? (Specify Yes Mexican, Puerto Rican, et Specify:	c.)	4. Race - American Ir Black, White, etc. Specify: BLAC	ndian,			
Maryland 21215-0036	within 72 ane. than "nai	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	ion uring most of working	16b. Kind	d of Business/Industr	у			
land 2	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) . Calvin Naskins	18. Mother's Name (First, N Nicole R						
Man	d 2 sho		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street ar  19cole Roberts (wither) 2611 Caven			Town, State, Zip Coo				
Baltimore,	Pages 1 and nent of Healt of Healt of Healt of Item 2 into or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place of Disposition)  20b. Place of Disposition (Name of cemetery, crematory or other place of Disposition)	Date	20c. Loca	ation - City or Town,				
Baltii	permit. Pag Department Important: any injury conce.		21. Signature of Tuneral Service License  22. Name and Address  Mullipides Management	of Hallity	0,00	1639 N.1	md.			
			23a. Part1. Enter/the disease, or complications that caused the death. Do not enter the mode of dying	, such as cardiac or respira	tory arrest,	Apr	proximate			
>	Physician /Medical	,	resulting in death)	CROTIZING	ENTER	000	erval Between set and Death			
	Examiner	_	Due to (or as a consequence of):  Sequentially list conditions,  Due to (or as a consequence of):							
,092	icate be executed physicien and s the burial-transit	cai Examiner	if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):							
89			IF FEMALE:							
.O. Box	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 mooths?  1 Yes 2 PNo 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetel death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day		Year			
Δ.	w requires that been signed b should be dete		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I. 23e.	Did tobacco use	e contribute to the ca	use of death?			
of Vital Records,	The law re ale has bee page 2 sho	Completed by			Was an autopsy performed?	24b. Were autopsy for prior to comple death? 1 Yes 2	tion of cause of			
ita	Physician: Th rthis certificate ral director, pag	Be (	eyaminer?	26. Place of Death (Check	only one)					
<u>&gt;</u>	d is	ည	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	4 Nursing Home 5	Residence 6	□Other (Specify)				
ion	ath. or: After t	ation;	2 Accident	at 28d. Des ? es 2 □ No	cribe how injury	occurred				
Division	at or Atte s atter de ii Directo id in by th	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Ph within 24 hours atter death.  To the Funeral Director: Atter th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	a, date and place, and due to inion, death occurred at the	to the cause(s) a time, date and p	and manner as stated place, and due to the	l. cause(s)			
)		M	29b. Signature and title of certifier  Falumb 29c. License Dook	number 5 / 0 / /	29d. Date	signed (Month, Day,	Year)			
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALISON FACK, 22 S. GREENE ST		ORE , A	10 2/20	01			
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 2 4 2004  Secure La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale  La Locale							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year 11:00 PM **Physician** 22 2004 May Dorothy Ethel Ronaghan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Arbutus 1238 Maple Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 1 ☐ M 2 K F Yrs. New York 22, 1915 89 Jan. Director 069-01-1988 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo MD Baltimore Arbutus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 United States 238 1238 Maple Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or iter any injury or other treumatic event, the Medical Examination. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 ģ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Mary Webber Engelbert Bonsel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Arrowwood Circle, Mt. Airy, MD 21771 Thomas J. Ronaghan, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 5-26-2004 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 Revens. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mfacelien Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence Allerorcleroris Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cons Examiner use as the burial-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown is been signed by to 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in the Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performs this certificate has funeral director, page 2 rmed? 2 No 1 🗌 Yes Attending Physician: 25. Was case referred to medical exampler?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3DOA Certification; To 28d. Describe how injury occurred 27. Manner of Death 1 ■Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A investigation 2 Accident the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 - Homicide 0 Hospitel pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) To the ATTENDING 29b. Signature May 24, 2004 PHYSICIAN D16200 NO COMPLETE CAUSE OF DEATH (Item 23a) (Type, Print) MAIDEN CHOICE LANE, BALTO. MD. 21228 h 30. Name and address of pe VORBERTO M. MacHIERN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		4	For State	State of Maryl		artment of Healt			ene g. No. 2 (	004	16531
			1. Decedent's Name (First, Middle, Last)		00.	- Inicate or Boa		2. Date of Death			3. Time of Death
ı	Physicia /Medic	ın	Frederick	G. J	ipes	, Sr.	1	mand		004 (	07:12 AM
2	Examin		4a. Facility Name (If not institution, give str	egt and number)	Hosp.	4b. City, Town or Local	tion of Death	•	4c. County	of Death WA	RD
	Funeral		5. Social Security Number 6. Sex	7. Age (In )	yrs. last birthday) Yrs.	If Under 1 Year If Ur Months Days Hou		8. Date of Birth (Month, Day,			ce (State or Foreign
	Director	-	218-14-7103 X	79	) 113.			EC. 26,	1924	Mary	
	yland		10a. State 10b. County	10c	: City, Town or L	ocation				100	d. Inside City Limits 1 ☐ Yes 2X No
	e Ma	Director	MD Howard	Н	anover	10f. Zip Code	***	10	g. Citizen of V	What Country	
	with th		10e. Street and Number 5995 Shady Lane			21076			USA	· · · · · · · · · · · · · · · · · · ·	, -
	ns 23	Funeral		. Was Decedent Ever	in U.S. 13.	Was Decedent of Hispani If Yes, specify Cuban, Me		cify Yes or No-	14. Rac	e - American	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23a or 28a-f show or other traumatic event, the Macical Examinar must be notified at	by Fun	1 Never Married 2 Married 3 ™ Widowed 4 Divorced	Armed Forces?  1X Yes 2 □ No If Yes, Give Year or Dates:			ecify:	nicani, etc.)		white	
21215-0036	2 hou	ted	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occupation kind of work done during	most of workii		6b. Kind of B	usiness/Indu	stry
215	ithin 7	Completed	(Specify only highest grade   Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	,		~ .		
12	filed within Hygiene. other then ont, the Me	Ö	17. Father's Name (First, Middle, Last)		Că	rpenter 18. M	Mother's Name	(First, Middle, N	Constr Maiden Suman		a
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	John W. Sipes			F	reida	D. Brog	lie		
ary	should be ind Mental is marked o	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mail	ng Address (Street and N	lumber or Rura	l Route Number,	City or Town,	State, Zip C	(ode)
	1 and 2 Health a iom 27 is		Frederick Sipes, Jr			Marriottsvil			ttsvill 20c. Location -		
ore	Pages 1 nent of He int: If iter		20a. Method of Disposition	moval from State		osition (Name of matory or other place)					
altimore,	t. Pa rtmen rtent:		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Stryige Licensee			dge Mem. Pk.  2. Name and Address of I	Facility		Elkrid		
Ba	Depariment of the permitted of the permi		Modh			ery L. Kaufm					ge MP, Inc.
3	430		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	death Do not er	250 Washingt oter the mode of dying, suc	ch as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition		pro	morgeal	Ca	ruhes	nac		
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of	nin					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	insequence of):	12.3					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							- 1	
60,	tate be executed obly sician and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence or):						
09289	physicate to the the the the the the the the the the	edical	d.								
Box (	eath certifica attending ph	M/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of p	regnancy Fetal death 3	□Ectopic pregnancy				ate of deliver	y Day Year
O. B	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)					
σ.	res that the de signed by the a be detached i	by Ph	Part II. Other significant conditions conf	inbuting to death but no	ot resulting in the	underlying cause given in	Part I.	23e. Did tob	oacco use con		e cause of death?
rds	v requires been sign should be							1 <b>X</b> Y	s 2 No	3 Proba	ibly 4 Dunknown
Records,	has bee	Completed						24a. Was a autops perform	y	Were autopoprior to com death?	sy findings available apletion of cause of
H IE	T age	Con						1 ☐ Yes	2000	1 ☐ Yes 2	2□ No
Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	ospital:	2 ER/Outpati	Other		h <i>Check on on</i> ome 5 ☐ Reside		her (Specify)	)
of	g Phys or this oral di	n: To	27. Manner of Dealh	28a. Date of Injury (Month, Day Ye	28b. Time			28d. Describe ho			
sion	Attending or death.	atlo	Natural 5 Pending investigation			M 1 ☐ Yes	2 🗆 No	Opt I perting (S)	troot and Mus	has as Rusal	Pauto Mumbor
Division	after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (S	- At home, farm, : Specify)	street, factory, office		28f. Location (Si City or Town	n, State)	Del Ol Hulai	noute reuniber,
	To the Hospitel or Attending Phwitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Examin	ner: On the basis of ex	amination and/or	ath occurred at the time, d investigation, in my opinio	date and place, on, death occur	and due to the c red at the time, d	ause(s) and m late and place	anner as sta , and due to	ited. the cause(s)
	the ithin 2 or the implet	Med	29b. Signature and title of certifier	and manner stated		29c. License nui			9d. Date sign		
	V/		1 Sach	~ m		D50	0870	7	may	20th	0004
	,611		30. Name and address of person who co	mpleted cause of deat	h (Item 23a) (Typ	e, Print)	1-10	asline	111	20	2029
	10		30. Name and address of person who co	5005 8 32. Registrar's	Signalina	1 Isen a		- www	uc)		0,001
	St Regis	ate trar	31. Date filed (Month, Day, Year) MAY 2 4 2004	32. negistrars	K Span	(E)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ) 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month SULLIVAN **Physician** KICHARD 2004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MD BAUTIMOR RANDALLSTOWN, NORTHWEST MOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 2, 1930 7. Age (In yrs. last birthday). 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Maryland 213-26-3907 1**X** M 2□ F Yrs. Director Usuel Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. neurelf, or items 23a or 28a-f show ent: If item 27 is marked other than "neturelf, or items 23a or 28a-f show ury or other treumatic event. The Modical Examiner must be notified at 1 ☐ Yes 2 No Owings Mills Baltimore Director Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21117 110 Cedarmere Rd. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White Be Completed by 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Industrial Sales Co. Rigger 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha E. Shelters Ezra David Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Cedarmere Rd., Owings Mills, Md. 21117 Lois M. Sullivan - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Importent: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park May 25, 2004 Sykesville, Md. 5 Other (Specify) 4 Donation 21. Signature of Fringral Service License 22 Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Pert1. Enter Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE STAGE Physician END PULMONARY DISTASE /Medical Due to (or as a consequence of) Examiner OBACCO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown MMONIA Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 After this 28c. Injury at Work? 28d. Describe how injury occurred d in by the fun-ral 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide ö To the Hospital within 24 hours a To the Funeral Completely filled in the Completely filled in t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D5391D 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, RANDALLSTOWN, MD A. MAHESHWARI, NORTHWEST

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 2 4 2004

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SU BOCK 0630 M MAY **Physician** ANNA 21 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year)
Feb. 7, 19 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. 84 Maryland Director 215-01-9721 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show the Medical Exer time must be notified at 1 ☐ Yes 2 X No Director Ellicott City MD Howard 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code ŏ United States or Items 23a 9549 Joey Drive 21042 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced 'natural' Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Administrative Assistant Rail Road permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other sny injury or other traumatic svent, QRCS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clara May Bishop George J. Hafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10805 Hickory Ridge Road, Suite 205 Columbia MD 21044
Date 200. Locatio Stephen R. Elville Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Cemetery, crematory or other place)
Lakeview Memorial 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-25-2004 ► Donation 5 ☐ Other (Specify) Eldersburg, MD Park
22. Name and Address of Facility Ambrose Funeral Home, Inc. Sign turn Funeral Se 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Urin any Days **Physician** /Medical Due to (or as a consequence of) Examiner Dehydh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical signed by the attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CAD, SUT 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a Wasan 1 ☐ Yes 2.2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 inpatient 2 ER/Outpatient 3 DOA 2 After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funaral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number D 2-8 9 98 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Patam ( 5-21-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 55 A inti CHERRY 54,4 LANE 211 Lourse /32. Registrar's Signature 31. Date liled (Month, Day, Year) MAY 2 4 2004 State Registrar

		1	For State Registrar		State o	f Marylar		artment of tificate o				giene Reg. No.	2004	16534
			Decedent's Name	(First, Middle, Last	')		-				2. Date of De		V	3. Time of Death
п	Physicia		MARY C	CLAIRE SMI	ITH						Month MAY	22.	2004	10:48 A.
	/Medic		4a. Facility Name (If	not institution, give	street and nu	mber)		4b. City, Tow	n, or Location	on of Death			ounty of Death	
	Examin	er						πv	OL/COM				BALTIMO	יחי
			GILCHRIS 5. Social Security Nu	T CENTER on 6. Se	×	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Un	der 24 Hrs.	8. Date of Bir	th	9. Birth	nplace (State or Foreign
	Funeral Director		212-30-9	1 [	] M 2 [ <b>x</b> F	73	Yrs.	Months Da	ys Hou	rs Min.	(Month, Da			untry) YLAND
		-	Usual Residence of											
	/lanc		10a. State	10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Man Fed	ţ	MD	HARFORI	D		BELAIR							1 ☐ Yes 2 📉 No
	1 28e	Director	10e. Street and Num	iber				10f. Zip Coo	ie			10g. Citiz	en of What Co	untry?
	38 o		1/106 BON	NETT PLAC	יותו ביי	IT C		210	15			US	Δ	
	death	Funerai	11. Marital Status	IVELT TEAC		edent Ever in t	J.S. 13.	Was Decedent If Yes, specify (	of Hispanic	Origin? (Spe	cify Yes or No		4. Race - Ame	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "natural", or Items 23e or 28e-f show item 27 is marked other than "natural", or Items 23e or 28e-f show other treumetic event, Ite Modical Examinar must be rediffied at	by Fur	1 Never Marrie			2 X No ive		1 ☐ Yes 2🌠			noarr, occ.,	5	Specific	HITE
ğ	2 hou	ed		15. Decedent's Edu	ucation		16a. Dece	dent's Usual Oc	cupation	most of working		16b. Kin	d of Business/	Industry
15	n "n	Completed	(Special Special Speci	fy only highest grad		(1-4 <i>o</i> r 5+)	life.	kind of work do DO NOT use re	ntired)	most of workii	ig			
7	iene iene r tha	E o	12TH GRA	_	Comago		SAL	ES/CLE	RK			RE'	TAIL SA	LES
b	e filed al Hygie other vent, III	Be C	17. Father's Name (	First, Middle, Last)					18. M	other's Name	(First, Middle	, Maiden S	Sumame)	
<u>a</u>	ould be Mental arked c	To B	LEROY MI	CHAEL					CE	ECELIA	WEIGMA	N		
7	2 should be and Mental is marked eumetic ev	-	19a. Informant's Na	me/Relationship (T	ype, Print)		19b. Maili	ng Address (St	reet and Nu	ımber or Rura	l Route Numb	er, City or	Town, State, Z	Zip Code)
S	nd 2 in the all		RAYMOND	CMTTH	ינו	JSBAND	1406	SONNE"	TT PLA	ACE UNI	T C E	BELAIR	R. MD	21015
á,	1 and 2 Health tem 27		20a. Method of Disp			20b.	Place of Dispo	osition (Name of	f		ate	20c. Loc	ation - City or	Town, State
altimore,	ages nt of t: If i			☐ Cremation 3 ☐! 5 ☐ Other (Specify)				_			10001			***
臣	it. Purtme	1	21. Signature of Fu			DR		GE CEMI 2. Name and A			2004		SVILLE	
Ba	permit. Pages 1 Department of H Importent: If ite any injury or ot		1	TienU/	0.		0.1	-04 100	7 0417					HOME, P.A.
			23a Part1 Enter th	ne disease, or comp	olications that	caused the dea	ath. Do not en	521 LOCI	dving, such	h as cardiac o	r respiratory a	rrest,	שו בוב	Approximate
			shock, or hear	rt failure. List only o	one cause on	each line.								Interval Between Onset and Death
	Physician		Immediate Cause ( disease or condition resulting in death)	rinai n	a/			c Br	1 Bas	Cond	cer			month
	/Medical Examiner		resulting in death,		Due to	o (or as a conse	quence of):							
п	LAGITITIO	L	Sequentially list con if any, leading to im	nditions,	b. Due to	o (or as a conse	anance of):							
	pd sit	ine	if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	mediate rlying	Due ic	(or as a conse	iquerice or).							
	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	Examine	that initiated events resulting in death) L	ast	c. Due to	o (or as a conse	aquence of):							
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9	ing p	Me	IF FEMALE:		00 1/									
Вох	eath certific attending p	an/	23b. Was decedent in the past 12		1 Live	utcome of preg birth 2 Te	tal death 3[	Ectopic pregn				2	<ol> <li>3d. Date of del Month</li> </ol>	Day Year
	e dea	sici	1 ☐ Yes 2)	<b>₹</b> No	4∐Preg 9∐Unk	gnant at time of nown	death 5	Other (specif	y)					
P.0	that the de led by the a detached	Physician/Me	9 Unknown				No		in C	Total I	23a Did	tobacco us	se contribute to	the cause of death?
	es tha igned be del	by	Part II. Other signif	icant conditions of	ontributing to	death but not re	esulling in the t	indenying caus	e given in r	ali.				robably 4 □Unknown
Records,	w requir been si should	ed										163 25	2,10	
Š	aw re Is be	Completed									24a. Was	psy	prior to	utopsy findings available completion of cause of
	The law ate has b	E 0									perf	ormed? 2.⊠`No	death?	2 □ No
Vital		a	25. Was case refer	red to medical					26. F	Place of Death	(Check only	one)		
	8 v =	0 8	examiner?	No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4[	Nursing Ho	me 5 Res	idence 6	Other (Spe	ecity) Hospoia
Division of	9 Ph	n: T	27. Manner of Deat		28a. Dat	e of Injury onth, Day Year)	28b. Time o	of 28c.	Injury at Work?		28d. Describe	how injury	occurred	
o	Attending For death.  ector: After by the funer	atio	1 Natural 2 ☐ Accident	5 Pending investigation	,	inter, Day 10ar)	Inquiry	М	1 Tes	2 🗆 No				
S	Attendi death. ctor: A	fice	3 🗌 Suicide	6 Could not be determined	208. Flat	ce of Injury - At	home, farm, si	treet, factory, of	fice			(Street and		ural Route Number,
Ö	after Direction of the	Certification;	4 🗍 Homicide		Duli	ding, etc. (Spe	ury)			Ł	o., o	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	al C	29a. Certifier	1 Certifying Ph 2 Medical Exen	ysician: To t	he best of my k	nowledge, dea	th occurred at t	he time, da	te and place,	and due to the	cause(s)	and manner as	s stated.
	e Ho e Fu	Medical	(Check only one)	2 ☐ Medical Exen	niner: On the and ma	basis of exami inner stated.	nation and/or i	nvestigation, in	my opinion	, death occurr	ed at the time	, date and	piace, and que	e to the cause(s)
	ro th vithin ro th	Me	29b. Signature and	title of certifier	,	1 87		29c. L	icense num	ber		29d. Date	e signed (Mont	
	->-0		DOM.	Antho	my 10	Mey	· me	De	252	20		MI	47 23	2,200 %
	V		30 Name and add	ress of person who	completed ca	use of death (It	em 23a) (Type	Print)		0 0		_	-0	
	Ÿ		4). A. 1	Ciley 1	BINC	6701	N-Ch	railes	Jt. 1	Balts	, md	212	05	
	St.	ate	31. Date filed (Mor	ith, Day, Year)	32.	Registrar's Sig	nature &	1	11					
	Regist		30. Name and addi	IAY 2 4 20	104	Jener	10	popo	AS .					

at 10:48 Am

May 22, 2007

Mary Umith

sician end buriel-trensit or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760, attending physician for use es the burie After this certificate hes t funeral director, pega 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be Completed by Physician/Medical Examine

**Physician** 

/Medical

Examiner

10a State

MD

by Funeral Director

Completed

**Funeral** 

Director

items 23e or 28e-f:

Pegas 1 and 2 should be filed within 72 hours efter death with the Marylend nant of Health end Mentel Hygiena. Int: If Item 27 Ia marked other than "naturel", or Items 23e or 28e-f show

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

	n h										
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):										
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (o	r as a consequence of	of):								
	d										
Part II. Other significant conditions	contributing to death but not res	ulting in the underlyin	g cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?  3 Probably 4 Unknown						
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?						
				1 Tyes 2 KNo	1 ☐ Yes 2 ☐ No						
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Home 5X Residence 6 □Ott	her (Specify)							
27. Manner of Death  12 Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occu	rred						
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, fac y)	28f. Location (Street and Num. City or Town, State)	ber or Rural Route Number,							
29a. Certifier Certifying P	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, deeth occurr tion end/or investigat	ed at the time, date end ple ion, in my opinion, death oc	ce, and due to the cause(s) end m courred at the time, date and place,	anner as stated. and due to the cause(s)						
29b. Signature and title of certifier	0 :		29c. License number		ed (Month, Day, Year)						
> Summet	2-mo PHY.	SICIAH	D5359	io MAY	18,2004						

MAY 18, 2004

MD 21090

BROADWAY

NORTH

BALTIMOLE

DHMH 16 Rev 6/95

State Registrar 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

ROOM bog

32. Registrer's Signature

Dy, MO

31. Date filed (Month Pay 2014 2004

Μ.

Certificate of Death

Sizemore

4b. City, Town, or Location of Death

1. Decedent's Name (First, Middle, Last)

Robert

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

DHMH 17 Rev 1/2001

within 24

Medical

5

State Registrar

(Check only one)

29b. Signature and title of certifier

MAY 2 4 2004

**ORIGINAL** 

32. Pegistrar's Signature

/ 11 11 11	- 1	1	-	- 4
Rag. No.	- 1	J	J	U
Death	3.	Time	of	Death

2. Date of I Day 18 May

Year

2004

4c. County of Death

Anne Arundel

Birthplace (State or Foreign Country)

Maryland

1530

10d. Inside City Limits 1 ☐ Yes 2√No

10g. Citizen of What Country?

USA 14. Race - American Indian,

Black, White, etc.

Specify: White 16b. Kind of Business/Industry

Armored Car

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

920 Crigger Road, Gambrills, MD 21054

20c. Location - City or Town, State

Sykesville, MD

22. Name and Address of Facility
Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

Approximate Interval Between Onset and Death

23d. Date of delivery Month

Day Year

24a. Was an autopsy

1 Yes 2 → To 3 Probably 4 Unknown

performed? 1 Yes 2 ₽No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOWATH C. KUNIAS 2 9 DEFUNC

Defense Hwy. Suite 104 Crofton Mp 2111

		1_ For	State of Ma	aryland / Dep	artment	of H	ealth a	and M			0001	10507
		Registrar		Ce	ertificate	of L	eath			Reg. No.	2000	
Phys	sician	Decedent's Name (First, Middle							2. Date of De Month	Day	_	3. Time of Death
1	edical	4a. Facility Name (If not institution			4b. City. T	Fown or	Location of	of Death	may	19	County of Deal	
Exar	miner	Johns Hepkins Bu	-	al Cuter			none			-	altimor	40
Funer	ral	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday	) If Under		If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da 11/20			hplace (Statelor Foreign (John) XYLAND
Direct		216-16-3169	1 MM 2□ F	80 Yrs.	Morturs	Days	riours	WILL.	11/28	5/23	MAT	KYĽAND
and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
Maryl	ō	MD	N/A	BALTI	MORE							1⊠Yes 2 □ No
r 28a	Director	10e. Street and Number	11/ 21	DILLI	10f. Zip (	Code			· ·	10g. Citiz	en of What Co	untry?
death with the Maryland ms 23e or 28e-f show	a D	339 CORNWALL	STREET			212	24			U	SA	
r deal	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decede	ent of His	spanic Ori	gin? (Spe i, Puerto i	cify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, Whit	
bours after tural; or its	by Ft	1 Never Married 2 Marr 3 Widowed 4 Divorced	ed 1 KL Yes 2 ☐ f If Yes, Give Year or Dates:		1 ☐ Yes 2		Specify:			1	Specify: T	<i>V</i> HITE
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s 1 and frequent Health		20a. Method of Disposition		20b. Place of Disp	osition (Nam	e of		AVE	• BALI	20c. Loc	cation - City or	). 21224 Town, State
0 20=5		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		OAK LAW				5/22	/04	BAL'	TIMORE	I. MD.
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ath cer attendir for use	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pre					2:	3d. Date of deli Month	very Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death 5	Other (spe	icity)						
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Duires puires n sign	D Q	Lung Cancer							101	∕es 2□	]No 3□Pr	obably 4 dunknown
law requires the specific state of the state	olete	J							24a. Was		24b. Were au	topsy findings available
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VIICAL ician: T certificat ector. pa	BeC	25. Was case referred to medical					26. Place	of Death	(Check only o			
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ing Pi	.: ::	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		lc. Injury Work			8d. Describe h	now injury	occurred	
r Attending er death. ractor: After	cati	2 Accident Investig	ot he	and Albama form of	M		es 2 🗆 f		19f Lagation /6	Stroot and	Mumbos os Pu	ral Route Number,
or At atter of Dirac	Certification:	4 Homicide determ	building, etc	ury - At home, farm, si c. (Specify)	reet, ractory,	опісе		-	City or Tox		Number of Ru	rai nobie Number,
spital	<u>a</u>	29a. Certifier 1 Certifyin	g Physician: To the best of	of my knowledge, dea	th occurred a	t the time	e, date and	d place, a	and due to the	cause(s) a	and manner as	stated.
To the Hospital or Attending Physicien: The law within 24 hours atter death. To the Funeral Director: After this certificate has completely filled in by the tuneral director, page 2:	edicai		Exeminer: On the basis of and manner sta	examination and/or in								
To th withir To th	\\\	29b. Signature and title of certifier				License					signed (Month	
,	X	Collen	ulon-	MD		D5	1185	>		Me	in 19,	2004
1	Ü	30. Name and address of person Collect Christmas	who completed cause of d	eath (Item 23a) (Type	Print)	~ C	Circle	B	altimor	re,	Mary la	nd 21224
	State istrar	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature							•	
DHMH 17 Rev	<	MAY 2 4 2	JU4 James	N.S. Jagan								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 15 PM **Physician** Betty Spielman 200 /Medical la Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner HICRE 8. Date of Birth (Month, Day, Year)
Dec 19, 1922 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** 5. Secial Security Number Min. Months Days Hours 1 □ M 2 🔀 F 82 219-18-2519 Director Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State item 27 is marked othar then "neturel", or items 23e or 28a-f ehow other treumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Summit Avenue 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White Completed by If Yes, Give Year or Dates: 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Housewife years Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Taylor Margaret Parker ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott Spielman/Son 1200 Summit Avenue, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pagas Department of Important; If it eny injury or o ö 1 Burial XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto./Wash.Crematory 6/2/2004 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, 1630 Edmondson Avenue, Catonsville, Inc. MD <u>21228</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conseq Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: esn If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has autopsy 1 ☐ Yes 2 No Vital Hospital or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3 DOA ot this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After Division 1 Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated within 2 To the I the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P16702 MA 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AYOBELE 900 SOUTH BALTIMORE AUENUE FRINCE 31. Date filed (Month, Day, Year) MAY 2 4 2004 32/Registrar's Signature Registrar

			For State Registrar	State of M	aryland /	•	rtment <i>tificate</i>					iene	04	16539
			Decedent's Name (First, Middle, I	Last)	-					-	2. Date of Dea	th		3. Time of Death
	Physici /Medi		Anthony Jo	hn Sigai							May 21	, 2004	Year -	10:15 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, g	give street and number	)		4b. City, T	own, or	Location	of Death		4c. Cour	nty of Death	
			932 Garden Drive	e #1A			Esse						timor	e
	Funeral Director		5. Social Security Number 213-42-2649	. Sex 7. A	ge (In yrs. last l	Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day JUNE 1,	1945	9. Birthin Cour Mary	place (State or Foreign http:/ land
	pur *	and the same of th	Usual Residence of Decedent  10a, State 10b, County		10c. City, To	wn or Loc	cation						1	10d. Inside City Limits
	fanyla sho	5												1 ☐ Yes 2 🐼 No
	the N	rect	Maryland   Baltim	ore	Esse	X	10f. Zip (	Code			1	0g. Citizen o	of What Cour	
	3a or	ā	932 Garden Dri	ve #1A			212	221				USA		•
	death ms 2	nera	11. Marital Status	12. Was Decedent		13. V			spanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	14. R	ace - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam for must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 XDivorced			i	Yes 2		Specify:		nicari, etc.)	Spec	lack, White, cify:	White
ŏ	72 hor	Completed	15. Decedent's (Specify only highest)	Education	16	a. Deced	ent's Usual	Occupa	ition	et of work	ina	16b. Kind of	Business/In	dustry
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pu	tal H	Be	17. Father's Name (First, Middle, La								(First, Middle, .			
<u>8</u>	1 Mer narke	မ	Joseph Stanley			N- 44-111-		(0)			Theresa		-	
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relationship Anthony Sigai/S								al Route Number			Code)
	1 and Healt em 2		20a. Method of Disposition	011	20b. Place	of Dispos	Garder	e of	1		Essex,	MD 2 20c. Location	21221 n - City or To	own. State
3altimore,	ages nt of t: If it		1 Burial 2 Cremation 3		ceme	tery, crem	natory or oth	ner place	· 1	5_22				
Ē	artme artme ortani injury		* 4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		rietro	-	emator Name and	2			_	Baltin	nore,	MD
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Box 68	eath certifical attending phy for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregnancy 2  Fetal dea	th 3□	Ectopic pre	gnancy					Date of delive	ery Day Year
0.0	that the des ed by the al detached fo	hysici	1 Yes 2 No	4☐Pregnant a 9☐ Unknown	t time of death	5 🗆	Other (spe	cify)	, , , , , ,	-		,	WO THI	Day Toal
rds, I	equires that en signed	ed by F	Part II. Other significant conditions	s contributing to death	out not resulting	in the un	iderlying cai	use give	n in Part I		23e. Did tol			ne cause of death?
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L L	ling F After Junera	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year) 28b	. Time of Injury	28 M	c. Injury Work			28d. Describe ho	w injury occi	urred	
isio	death death stor:	icat	2 Accident investigat 3 Suicide 6 Could no	h-	iuny - At home	form etre			res 2□	-	28f Location (St	reet and Nur	nher or Rum	I Route Number.
ĕ	al or A s after Il Direct	Certification;	4 Homicide determine	28e. Place of In building, e	tc. (Specify)	iaiii, siic	ot, ractory,	Ottice			City or Town	, State)	ngor or rigid	in riddio realistici,
•	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edicai (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examination a	ge, death and/or inv	occurred at estigation, i	t the tim n my op	e, date an inion, dea	nd place, a	and due to the ca	ause(s) and rate and place	manner as st	tated. the cause(s)
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1	- StateAmend Items 23a	1923921 PCL 111190C		unicate or t	Dealli		Reg. No.	2004	1001
1	1. Decedent's Name (First, Middle, L					2. Date of De	ath		3. Time of Deat
ician	DARRIN	SMITH	1			Month O 2	Day	2004	3:00 A
dical niner 4	a. Facility Name (If not institution, g			4b. City, Town, or	r Location of Dea	th	4c. (	County of Death	1
	Sin al Hospita	al of Balti	move		imore.	City			
	5. Social Security Number 6.	. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	th ay, Year)	Cou	place (State or Fore
"	212 86 5867	10 m 20 F 3 G	Yrs.			July 11,	1969	1 1	V.D.
	Jsual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Loc	cation					10d. Inside City Lin
	1/2 1/6		3A Itin						1/2 Yes 2
Funeral Director	10e. Street and Number	1.	JH 1411	10f. Zip Code			10a Citiz	en of What Cou	
급		z		2120	c~			USA	211d y 1
era 1	1620 Madison 3	12. Was Decedent Ever	in U.S. 13 W	Vas Decedent of Hi	ispanic Origin? (	Specify Yes or No		4. Race - Ameri	ican Indian
Ë,	1 Never Married 2 Married	Armed Forces?	if if	Vas Decedent of Hi Yes, specify Cuba	ın, Mexican, Pue	rto Rican, etc.)		Black, White	
by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐Yes 2☐XNo	Specify:			Specify: Place	16
ed	15. Decedent's		16a. Decede	ent's Usual Occupa	ation		16b. Kin	d of Business/Ir	ndustry
Completed	(Specify only highest g		(Give k	kind of work done of OO NOT use retired	during most of wo d)	orking		1	
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De C	17. Father's Name (First, Middle, Las	st)			18. Mother's Na	me (First, Middle	, Maiden S	Sumame)	
To B	William Smi	Sh			Mani	Wilma	1.		
	19a. Informant's Name/Relationship		19b. Mailing	g Address (Street a	and Number or F	lural Route Numb	er, City or	Town, State, Zi	p Code)
	Sholewhet Hav	ock cals	1620	& Mudison	N St Bo	Himes MG	212	05	
	20a. Method of Disposition		Ob. Place of Dispos			Date		ation - City or T	own, State
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. 2	21. Signature of Funeral Service Lic	ciny)	Mt CARME	Name and Address	ss of Facility	ste Fance	DOG	me 191	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY 2004 20, 7:02 A M **Physician** SCHAPIRO MILDRED /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours MD 1 ☐ M 2 😿 F 88 212-42-0247 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ahow r than "natural" or Itema 23a or 28a-f ahov The Modical Examinar must be notified at 1 ☐ Yes 2 🔀 No BALTIMORE by Funeral Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21208 25 SADDLE COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: WHITE Maryland 21215-0036 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed College (1-4or 5+) Elementary/Secondary (0-12) **FURNITURE** SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 Is marked of traumatic ever STEINBERG FANNY SCHOOLNICK **ISAAC** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 25 SADDLE COURT - BALTIMORE, MD 21208 JOAN MILLER / DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 5/21/2004 RANDALLSTOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Se 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ▶ inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if yone cause on each line. 23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months 4☐ Pregnant at time of death 5 Other (specify) 2 🗆 🕅 0 Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ⊕bhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate has 1 Yes 2 No 2 No 1 Yes 26. Place of Death Check on one funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ☐ No After this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined filled in by 4 - Homicide Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier impleted cause of death (Item 23a) (Type, Print) cere Tree 30. Name and addless of person eman Men 32. Registrar's Signature 31. Date filed (Month, Oay, Year) State Registrar MAY 2 4 2004

**ORIGINAL** 

			1- State of Maryland / Department of Health and M Certificate of Death		iene g. N2004 16542
	Physici		1. Decedent's Name (First, Middle, Last) VEDA M THOMAS	2. Date of Death Month	Day Year 21 2004 0322 AM
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  A I NT A GIVES HEALTHER  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1 Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, LOC2	4c. County of Death  A  9. Birthplace (State or Foreign Country)  Year)  Year)  Year)  A
	Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD N/A BALTIMORE		10d. Inside City Limits 1 及Yes 2 ☐ No
	3c or 28s	Il Direc	10e. Street and Number 10f. Zip Code 1018 WICKLOW RDAD 21229	10	Og. Citizen of What Country?
2-0036	72 hours after death with the Maryland natural', or Itams 23s or 28s-f show disal Examiner must be molified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ✓ Marned 1 □ Yes 2 ☑ No If Yes, Specify Cuban, Mexican, Puerto 1 □ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importament if itam 27 is marked other then "natural", or itams 23s or 28e-f show empty injury or other treatmetic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  12-th grade  N/A  16a. Decedent's Usual Occupation (Give kind of work done during most of working iffe. DO NOT use retired)  LERK  17. Father's Name (First, Middle, Last)  18. Mother's Name	ing	16b. Kind of Business/Industry  U.S. Postal Service  Jaiden Sumame)
Maryland	should be nd Mental marked o umatic eve	To Be	BROOKS PALMER CLAR	A	UNK
	1 and 2 st Health and lam 27 is n		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura  1018 WICKLOW ROAD	BALTIN	MORE, MD 21229
Baltimore,	Pages 1 nent of H ant: If ita		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	1 1	BAUTIMORE, MD
Balt	permit. Pag Department Important: I any injury o		21. Signature of Fune a) Service Licensee  22. Name and Address of Facility  VAUGHN C. GREENE  5151 BALTIMOREN	FUNERA	L SERVICES PIKE BALTO MD 21229
	Medical /Medical Examiner	dical Examiner	23a. Part1. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or head ailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	or respiratory arre	st, Approximate Interval Between Onset and Death
O. Box 6	ne death certific the attending p hed for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of delivery  Month Day Year
rds, P.	quires that the signed by all do detaction	by	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?  s 2 No 3 Probably 4 Valunknown
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Division o	ding h. After fune	Certification:	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	28d. Describe hov	
Divi	To the Hospital or Attan within 24 hours after deat To the Funaral Director: completely filled in by the	Certifi	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
>	he Hospital in 24 hours a ha Funaral I pletely filled	edical	29a. Certifier  (Check only one)  1 ★ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 ★ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca od at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the lead the lead to the lead to complete	N	29b. Signature and title of certifier  29c. License number  D 2 2 6 4 8		d. Date signed (Month, Day, Year)  05/21/04
	19		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JEROME F. Snyder MD, 900 SOUTH CATOWAVE NUE BA		· · · · · · · · · · · · · · · · · · ·
	Sta Registr		31. Date filed (Month Pay Year)  NAY 24 2004  32. Registrar's Signature  Sparish	-(1110006	"Torid al ad al

			For State	State of M	1aryland		artment of I		d Mental Hy	giene Reg. No 200	14	16543
			Registrar  1. Decedent's Name (First, Middle, La	st)					2. Date of De		- 1	3. Time of Death
	Physici		Socia J.	201					Month	Day	Year	451 AM
	/Medio Examin		4a. Facility Name (If not institution, give	e street and number	r) .		4b. City, Town,	or Location of De		4c. County of	of Death	
1	LXAIIII	CI	Ann And Il	hedical	رعامی	_	Anna	apolic		Anne	- Ac	andel
	Funeral		Social Security Number     6. S	ex 7. A	Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bi	rth av Yearl	9. Birthpl	ace (State or Foreign try)
10	Director		422-22-0297	□ M 2 <b>XCX</b> F	76	Yrs.	Months Days	Hours IV	May 29	, 1927 A	laba	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 City	, Town or Lo	nation				10	Od. Inside City Limits
	ehov	<u>_</u>	,									1 ☐ Yes 2√ No
	Ba-f	ecto	MD Anne Art	indel	An	napol:	LS 10f. Zip Code			10g. Citizen of W	hat Coup	
	with t	Funeral Director	130 Hearne Road	An+ 10:	1			1 / 01			nat Coun	ay:
	eath	erai	130 Heathe Road	12. Was Deceder		3. 13.		L401 Hispanic Origin?	(Specify Yes or N	USA o- 14. Race	- Americ	an Indian.
	iter d	ä	1 Never Married 2 Married	Armed Forces	?				(Specify Yes or Nuerto Rican, etc.)	Black	, White,	etc.
936	urs al	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2 🛣 No	Specify:		Specify:	Whi	.te
5-0036	172 hours after death with the Maryland "natural", or iteme 23a or 28a-f ehow calcul Exaculation coulding at	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Occu kind of work done	pation	working	16b. Kind of Bus	siness/Inc	lustry
21	- E 69	ed C	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT use retire	ed)	Working			
2121	er th	S	12			Sear	nstress			Drap		
Maryland	2 should be filled within and Mental Hygiene. Ie marked other than eumatic event, the Ma	Be	17. Father's Name (First, Middle, Last					18. Mother's	Name (First, Middle	e, Maiden Sumame	9)	
yla	Ment Ment Marked Marked	ည	Unknown	Carawa	ay .				tie Ball			
Nar	2 sh and le m		19a. Informant's Name/Relationship						r Rural Route Numb			
	1 end Health em 27 ther t		Mary Jane McGil	(Daughte		1214	+ Brietwe	rt Aven	ue, Odeni	20c. Location - 0	1113	wn State
altimore,	ges If of H		1 🗆 Burial 2 🛣 Cremation 3 🛭				sition (Name of matory or other pla	i				
ţi	t. Partimer rtant		'4 □Donation 5 □ Other (Speci		Met		ematory  2. Name and Address		24/2004	Baltimo	re,	MD
Bal	permit. Pages 1 and 2 should be filed within Deperment of Health and Mental Hyglene. Important: If item 27 le marked other than any liqury or other treumatic event, Tre M. ODCC.		21. Signature of Funeral Service Lize	<del></del>		24	Hardesty	<sup>r</sup> Funera	l Home, lue, Anna	P.A. polis, MD	214	01
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caus one cause on each	ed the death line.	. Do not ent	ter the mode of dy	ing, such as car	diac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pre	unon							Onset and Death
	/Medical		resulting in death)	Due to (or a	is a consequ	ence of):						
	Examiner		Sequentially list conditions,	b. En	aphys	cma	٠					
	be sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for a	is a conseeu	euce ori:						
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	is a consequ	ence of):	1×				-	
8760,	be e sician buria	a E									Ī	
687	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		_ d								
Вох	nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			42. 12. 22.			23d. Date	of delive	ry
_	0 0	cia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant	at time of de		□Ectopic pregnand □ Other (specify) _	;y 		Mon	th	Day Year
P.O.	t the by the	hys	9 □ Unknown	9□ Unknown								
	requires that the de een signed by the a hould be detached f		Part II. Other significant conditions	contributing to death	but not resu	Ilting in the u	nderlying cause g	ven in Part I.	23e. Did	tobacco use contri		
ord	w require been si should b	fed	Type C Di	ubertes	Melli	tos			_	Yes 2□No	3 Prob	ably 4 Unknown
900	S to	Completed by							_ 24a. Was	opsy DI	ere autor	osy findings available inpletion of cause of
R	T page	Con							perf		eath? □ Yes	2 No
/ita	ilcian: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?						Death (Check only	one)		
of Vital Records,	Physician: this certific al director,	Z	1 Yes 2 No				IL SLI DOA		ng Home 5 ☐ Res			)
ū		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, L	jury Day Year)	28b. Time o Injury	Wo		28d. Describe	how injury occurre	ed	
sio	tend death tor: /	cati	2 Accident investigation 3 Suicide 6 Could not I		lainer As ha			Yes 2 No	29f Location	(Street and Numbe	s or Rum	I Pauto Number
Division	or Atter of Direction by	Certification;	4 Homicide determined	building,	etc. (Specily	) )	reet, factory, office			wn, State)	i oi mara	r riodie i variber,
_	pltei ours a erel		29a, Certifier 1 Certifying P	hysician: To the be	st of my know	tseh enhelv	h occurred at the t	ime date and n	lace, and due to the	cause(s) and man	ner as st	ated
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical		miner: On the basis and manner	of examinat							
	To the within To the comp	M	29b. Signature and title of certifier	1			29c. Licen	se number		29d. Date signed		
)	÷		1/26/				D:	5892Z		5/2	1/01	1
	10		30. Name and address of person who	completed cause of	f death (Item	1	1 .	0 [	1005	medica	al F	1 Openan
	,		Michael Lee	- Ann	Arul		reducil	Center	Annax	solisimo	215	601
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 4 2004	22. Regis	strar's Signat	does						

			For State Registrar	State of Marylar		artment of F tificate of			ne No2004	16544
	Physici	an	1. Decedent's Name (First, Middle, Las	1)	1)	Isch		2. Date of Death Month	Day Year	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	10 1		r Location of Death	1.1000	4c. County of Deat	1
			JOHNS HOPWINS BO 5. Social Security Number 6. Se	VIEW MEDICA.	last hirthday)	If Under 1 Year	HMOVE	8 Date of Birth	n/a	nplace (State or Foreign
	Funeral Director			□M 2	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 4 / 7 / 7 ]	MAR	YLAND
	and 1		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	• Mary	tor	MD BALTIMO	ORE	DU	NDALK				1 ☐ Yes 2 No
	or 284	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	leath v	erai	2058 LARKHALL  11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of F	122 Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	USA 14. Race - Ame	ncan Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  The marked other then "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar man be notified at Once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cubi	Specify:	o Rican, etc.)	Black, White	a, etc. HITE
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		(Give	lent's Usual Occup kind of work done	during most of wor.	king 16t	. Kind of Business/	
121	within iene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	unkn	OO NOT use retire	a)		unknown	
	be filed stal Hygin stal other event, I	BeC	17. Father's Name (First, Middle, Last)		GIIRI	OWII		ne (First, Middle, Mai	den Sumame)	
Maryland	should k ind Ment i marked umatic e	으	JOSEPH ULSCH  19a. Informant's Name/Relationship (7	ives Print)	10h Mailin	a Address /Street		BERTHOLD		(in Code)
	and 2 si salth an n 27 is n		MR. CHARLES BEI	• • • • • • • • • • • • • • • • • • • •				BALTIMOR		21222
<b>O</b>	Pages 1 a nent of Hea nt: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □	l .	Place of Dispo cemetery, cren	sition (Name of natory or other pla	сө)	Date 200	Location - City or	Fown, State
<u>=</u>	it. Pag irtment irtent: njury d		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	BA			ORY 5/2	4/04 B ERAL HOM	ALTIMOR	E, MD.
B	permit. Departr Importe any inji		Vaene (	Carton	/ 1			E. BALTI		D. 21222
			23a. Part1. Enterthe disease, or comp shock, or heart failure. List only	olications that caused the dea	th. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
) 1	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lympho	ma					Weeks
	Examiner	ď		Due to (or as a consect	quence of):	7				Wears
	sit ød	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to or as a conse	uence of):					7
<u>,</u>	rate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):					
8760	ate be hysicla the bur	dicai	(	d						
9 ×	eath certific attending pl	/Mec	IF FEMALÉ:	23c. If yes, outcome of pregn	ancy				23d. Date of deli	Werv
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Who 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown		Ectopic pregnancy Other (specify)	/		Month	Day Year
٠.	that the de ed by the a detached f		Part II. Other significant conditions of	entributing to death but not res	sulting in the ur	nderlying cause giv	ren in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w requires that been signed be should be det	ed by					-	1 ☐ Yes	2 □ No 3 □ Pro	babiy 4 Unknown
Records,	e 2 sho	ompieted				<u> </u>		24a. Was an autopsy performed	prior to d	topsy findings available ompletion of cause of
		e Col	25. Was case referred to medical				26 Place of Dea	1 Yes 2 X	No 1 ☐ Yes	200 No
	Physicia this cert al direct	To B	examiner? 1 Tyes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	000	ome 5 Residence	e 6 □Other (Spec	ify)
Division of	ding Pl h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 ∐No	28d. Describe how i	njury occurred	
VISIO	or Attending Physician: after death, Director: After this certification by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Place of injury - At h			163 2 110	28f. Location (Stree City or Town, S	t and Number or Ru	ral Route Number,
٥	ital or A irs after ral Dire lled in by			building, etc. (Speci						
	To the Hospital within 24 hours of the Funeral completely filled	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the tire restigation, in my o	me, date and place pinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	$\overline{\mathcal{O}}$		29c. Licens	e number	29d.	Date signed (Month	, Day, Year)
	~		> Mulu	NO N	W	PIC	7464	N	1ay 19	,2004
			30. Name and address of person who	+ MID	m 23a) (Type, 494	10 Easy	tern Aco.	nue Bali	Innore M	1021224
	Sta		31. Date filed (Month, Day, Year) MAY 2 4 2004	32. Registrar's Sign	ature		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 1.009	11	, 2004 D21224
DHM	Registr 4H 17 Rev 1/2	- 10	mai & 4 2004	32 Registrar's Sign	April	de -				

ORIGINAL

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Section   Sect	thin ean	ig.	Elementary/Secondary (0-12)	College (1-4or	5+) life	DO NOT L	use retired	0				
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Purpose   Purp	Shou man	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Addres	s (Street	and Number or Ru	ıral Route Numb	er, City o	r Town, State, Z	ip Code)
Section   Sect	d 2 th a trac		Frank I Windham	olei Im (Ca	4) en	17.1			•			***
Section   Sect	1 an Hea em ?			SKI JI. (50	20b. Place of Dis	position (Na	me of			200. Lo	and 212 cation City or	2.4 own, State
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23a Pint: finter the desses, or complication spline caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Orient and Between Orien	82589		(ib/arle)	Khorne	rki'	1005	Dun	dalk Ave	· Balto.	rune Mo	21224	es P.A.
Due to (or as a consequence of):  d.    Due to (or as a consequence of):   Due to (or as a consequence of death of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Due to (or as a consequence of):   Du	Examiner	ıer	Immediate Cause (Final disease or condition resulting in death)	a. LUNG C	ANCER s a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Munknown  24a. Was an autopsy prior to completion of cause of death?  1   Yes   2   No   3   Probably   4   Munknown  24b. Were autopsy findings availabined to completion of cause of death?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1   Yes   2   No   No   No   No   No    28a. Date of Injury   28b. Time of Injury   28b	sicie bur	ā	that initiated events	c. Due to (or a	s a consequence of):							
1   yes 2   No 3   Probably 4   Unknown	the death certi yy the attending ached for use a	nysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗶 No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3					2		*
24a. Was an autopsy performed?    24a. Was an autopsy performed?   24b. Were autopsy findings availa prior to completion of cause (death?)   25b. Was case referred to medical examiner?   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Was case referred to medical examiner?   25c. Place of Death (Check only one)   25c. Place of Death (Month, Day Year)   25c. Place of Death (Month, Day Year)   25c. Place of Death (Check only one)   25c. Pl	= 00	УР	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying	cause giv	en in Part I.	23e. Did t	tobacco u	se contribute to	the cause of death?
24a. Was an autopsy performed? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    25. Was case referred to medical examiner? 1   Yes 2   No    26. Place of Death (Check only one)  27. Manner of Death   Mospital:   I   Inpatient   2   ER/Outpatient   3   DOA    28a. Date of Injury   Month, Day Year)  28b. Time of Injury   Month, Day Year)  28c. Injury at Work?   28d. Describe how injury occurred  28c. Injury at Work?   28d. Describe how injury occurred  28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28c. Injury at Work?   1   Yes 2   No    28d. Location (Street and Number or Rural Route Number, determined on an anner as stated. City or Town, State)  29c. License number   29d. Date signed (Month, Day, Year)    30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)    32. Registrar's Signature   29d. Date signed (Month, Day, Year)    32. Registrar's Signature   29d. Date signed (Month, Day, Year)    33. Date filled (Month, Day, Year)    34. Date filled (Month, Day, Year)    35. Registrar's Signature   29d. Date signed (Month, Day, Year)    35. Registrar's Signature   29d. Date signed (Month, Day, Year)    35. Registrar's Signature   29d. Date signed (Month, Day, Year)    35. Registrar's Signature   29d. Date signature   29d. Date signature   29d. Date signature   29d. Date signature   29d. Date signature   29d. Date signature   29d. Date signature   29d. Date signa	uires sign								10	Yes 2	No 3∏Pro	bably 4X Unknow
autopsy performed?    Composition of cause of death of the performed?   Composition of cause of death?   Composition of cause of death.   Composition of cause of dea	peen	ete							04-146-		045 144	
25. Was case referred to medical examiner?  1   Yes   2   No	S 50	n idu							auto	psy	prior to c	opsy findings available ompletion of cause o
25. Was case referred to medical examiner?  1   Yes   2   No	ate pag	Ö										2 No
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury M 1 Yes 2 No 28b. Time of Injury M 1 Yes 2 No 28b. Linuty at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28c. Injury at North Number or Rural Route Number, of Injury of Injury of Injury of Injury of Injury of Injury of Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 3 Suicide 4 Homicide 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 2 North Number or Rural Route Number, of Injury of Injury of Injury of Injury of Injury of Injury at Work? 2 North Number or Rural Route Number, of Injury of I	rtific tor,	0						26. Place of Dea	ath (Check only	one)		
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093  31. Date filed (Month, Day, Year)  328f. Location (Street and Number or Rural Route Number, factory, office 28f. Location (Street and Number or Rural Route Number, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093	두 두 교			28a. Date of In		of	28c. injun	at	28d. Describe		-	" HOSE TOE
29a. Certifier (Check only one)  29b. Signature and ditle of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD  2300 DULANEY VALLEY RD. TIMONIUM, MD 21093	ding Pi. Afte	101			ay rear) Injury							
29a. Certifier (Check only one)  29b. Signature and delete of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD  2300 DULANEY VALLEY RD. TIMONIUM, MD 21093	el or Atten s after deat il Director: id in by the	Sertifica	3 ☐ Suicide 6 ☐ Could no	be 28e. Place of Ir		street, factor	y, office		28f. Location ( City or To	Street and wn, State,	d Number or Ru	ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	he Hospil in 24 hour he Funera	edicai	(Check only 2 Medical Ex	aminer: On the basis	of examination and/or							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	omp	Ž	29b. Signature and Atle of certifier			29	c. Licens	e number		29d. Dat	e signed (Month	Day, Year)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1						Nu	2720		4	5/211	64
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	h		20 Name and 11	15	death (line 00-) IT	Dei-1)	シー	J 1 L3			1-1	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	J.			·						0.0 =		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 15					LLEY I	<b>.</b>	TIMONIUM	, MD 21	093		
Registrar WIA 6 4 2004 A ADOMA /			31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	1						

DHMH 17 Rev 1/2001

MAY 21, 2004 3:15 p.m.

CAROLINE WIOSKOWSKI

Physicia / Medic Examine 23s or 28s-1 show and present the political Examine mail be notified at Director	al	Decedent's Name (First, Middle, Last)     MICHAEL     4a. Facility Name (If not institution, give s	7						2 Date of Do			
Funeral Director	er		street and number	).		Ab. City, Tow	NET n. or Locat		2. Date of De Month	Day Z	2004 Dunty of Death	3. Time of Deat
		JOHNS HOPKIN  5. Social Security Number 6. Sex	13 H	OSPITA  Ige (In yrs. last		If Under 1 Ye	B ar If Un	ALTIMO				N/A  place (State or Foi
28e-f s		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo				001.10	,1909		10d. Inside City Li
5 0	Director	MD N/A  10e. Street and Number	-		BAL	TIMORE 10f. Zip Cod		<u> </u>		10g. Citizer	n of What Cou	-
al', or items 23a or 28e-f show Examine must be notified at	by Funeral [	915 DROHOMER PLAC	12. Was Deceden Armed Forces 1	6? { No		Was Decedent f Yes, specify 0 1 ☐ Yes 2 汉	of Hispanic Juban, Mex		pecify Yes or No Rican, etc.)		Race - Amer Black, White	, etc.
- 2	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	1	(Give life. L	dent's Usual Ookind of work do	cupation ne during tired)	most of work	king		of Business/I	
nd Mental Hygiene. marked other than " imatic event, the Mer	Be	17. Father's Name (First, Middle, Last) NORTON	•	ı	ASNE			other's Nam	e (First, Middle			BLUMBER
h and Meni 7 is marke treumatic	<b>P</b>	19a. Informant's Name/Relationship (Type ADRIENNE ASNER /		4	19b. Mailir	ng Address (Str	eet and Nu	umber or Ru	ral Route Numb			ip Code)
ant of Health it: if item 27 y or other tr		20a. Method of Disposition  1 ABurial 2 Cremation 3 S 4 Donation 5 Other (Specify)		е сете	e of Dispo etery, cren	sition (Name or natory or other TEFIORE	place)	1	Date	20c. Loca	tion - City or 1	Town, State
Department Important: it sny injury o		21. Signature of Funeral Service Ligense		HOSES	22	. Name and Ad	Idress of F	acility S	OL LEVI	NSON 8	BROS.	
nysician Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ventu	ricular	Do not ent		dying, sucl					Approximate Interval Between Onset and Dea
sicien and burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequent	ir fevo	g dise	ase					10 yez
by the attending phy stached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of death	ath 3	Ectopic pregna				230	d. Date of deir	very Day Yea
signed d be de		Part II. Other significant conditions cor	,	but not resultin	ng in the u	nderlying cause	given in P	Part I.		obacco use Yes 2 🔀 i		the cause of deal
cate has been page 2 should	Completed by								24a. Was auto pend 1 \( \text{Yes}	psy rmed?	prior to c death?	topsy findings ava ompletion of caus
this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	lospital: 1 🔀 Inpa	tient 2 ER	VOutpatien	nt 3 DOA	Other		th (Check only o		Other (Spec	ify)
<b>≒</b> 70	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of In (Month, D	ijury 28 Day Year)	3b. Time of Injury		njury at Work? 1 🗋 Yes	2 🗌 No	28d. Describe			
after Dire		4 Homicide determined	building,	njury - At home etc. <i>(Specify)</i>					City or To	wn, State)		ral Route Number,
in 24 hours the Funarei pletely filled	Medical	29a. Certifier 1⊠Certifying Physical (Check only one) 2 ☐ Medical Examination	sician: To the bes ner: On the basis and manner:	of examination	edge, death and/or in	vestigation, in r	ny opinion,	, death occu	, and due to the rred at the time,	date and pl	ace, and due	to the cause(s)
To the comple	Σ	29b. Signature and title of certifier		MP		R	ense numi	± 000	0	May	signed (Month	2004
Sta		30. Name and address of person who or CHRISTOPHER HO	PEMANN	f death (Item 23		Print) (IV) Ha	PITAL	, 600 A	KETH WELF	EST. E	BALTIMO	ee, MD 21

		1 - For State Registrar	State of Maryl	and / Depa	artment o	of Health and of Death	d Mental Hy	_	104 1654
Physici /Medic Examin	ai	Decedent's Name (First, Middle, Las      Betty Jane  4a. Facility Name (If not institution, give Saint Joseph I	Blankenship		4b. City, To	wn, or Location of De	son	Day AY 21.	Year  Year  10:55  yof Death  Baltimore
Funeral Director		5. Social Security Number  217-22-0634  Usual Residence of Decedent		vrs. last birthday) 75 Yrs.	If Under 1 \ Months   D		Irs. 8. Date of Bir (Month, Da Dec. 7	th year) 1928	9. Birthplace (State or Forei Country) Maryland
the Maryland 28a-f ehow	ector	10a. State 10b. County	imore 10c.	Cocke	ysville			10g Citizen et	10d. Inside City Limi 1 ☐ Yes 2X N
and 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at	sted by Funeral Director	826 Staffordshire  11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  15. Decedent's Ed	12. Was Decedent Ever in Armed Forces?  1 Yes 2 X No If Yes, Give Year or Dates:	16a, Dece	Was Deceden If Yes, specify 1 ☐ Yes 2   Ident's Usual C	t of Hispanic Origin? Cuban, Mexican, Pu No Specify:		US. 14. Re Bla Speci	
be filed within stal Hygiene. Id other than "	To Be Completed	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  John Collie Blanke	College (1-4or 5+) 2 nship	Secre	etary	Caro	lame (First, Middle,	, Maiden Suma andt Dav	wson
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marks any injury or other traumatic once.		19a. Informant's Name/Relationship (7)  Donald Sean Knight  20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Center)	/Son   20	826 S b. Place of Dispo cemetery, crer ulaney [emorial	Staffor sition (Name natory or othe Valley Garden Name and A	of r place) May  1s 2  Address of Facility	Date 25, 004	20c. Location Time	- City or Town, State Onium, MD
te be ysicia ie bur	licai Examiner	23a. Part1. Enterthe disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	sequence of):		f dying, such as card	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregn Other (specif				ate of delivery onth Day Year
es bed	þ	Part II. Other significent conditions co	ntributing to death but not	resulting in the ur	nderlying caus	e given in Part I.	23e. Did to		tribute to the cause of death?
	Completed						24a. Was autop perfo	rmed?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
hysi his c	cation: To Be	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	Hospital: 12 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c.	Other	Home 5 Resid	tence 6 □Ott	
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spesicien: To the best of my li	ecity)			City or Tow	m, State)	ber or Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	ner: On the basis of exam and manner stated.	and/or inv	estigation, in	my opinion, death occense number	curred at the time, o	date and place.	and due to the cause(s) and (Month, Day, Year)
Stat Registra	te	30. Name and address of person who compared to the state of the state		LER DR		OWSON MA	RYLAND 8	21204	

			For		State of Mary	yland / Depa	rtmei	nt of Health and	Mental Hy	giene	0.001	
			1 - State Registra	ar		Cer	tifica	te of Death		Reg. No.	2004	16548
ľ	Physici	an	1. Decedent	's Name (First, Middle, L	ast) + ++	BUN	ct	t	2. Date of De	eath Day	2004	3. Time of Death Z310 M
No.	<ul><li>/Medic</li><li>Examir</li></ul>		4a. Facility N	lame (If not institution, gi	ive street and number)			, Town, or Location of Deat		4c.	County of Death	23.0
	CAUTIN		UM	mc			B	altimore			NIA	
	Funeral Director	(2)	166-3	6. 6985 ence of Decedent	Sex 1 □ M 2 S F	n yrs. last birthday) Yrs.	If Unde Months	or 1 Year If Under 24 Hrs Days Hours Min.		2.8	9. Birth	place (State or Foreign ntry)
	yland 10W		10a. State	10b. County	10	Oc. City, Town or Lo						10d. Inside City Limits
	Ba-fat	Director	MD			Baltin	70					1 <b>K</b> es 2 No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatih and Mental Hygiene. If item 27 is marked othar than "natural", or items 23a or 28a-f ahow or other traumatic event, it a Maraical Examinations could be a could be a could be a contract.		10e. Street a	and Number	Jamoda	1)	10f. Z	173G		10g. Citi:	zen of What Cou	ntry?
	death	nera	11. Marital S	itatus	12. Was Decedent Eve Armed Forces?	er in U.S. 13. y	Vas Deci	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or Note Rican, etc.)	0-	14. Race - Ameri Black, White,	
36	72 hours after natural', or ite	by Funeral		er Married 2 Married	1 Tes 2 No If Yes, Give Year or Dates:			2 XNo Specify:	10 (110411, 010.)		Specify: A	lock
5-0036	2 hour	ted b	34144100	15. Decedent's f	Education	16a. Deced	lent's Us	ual Occupation		16b. Kir	nd of Business/Ir	ndustry
21215	within 7 iene.	Completed	Elementar	(Specify only highest g ry/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT	ork done during most of wo use retired)	nxing	D	1- 0:	1.1ch
	filed w Hygier Athar th	Cor	17 Father's	Name (First, Middle, Las	year	1 50	Pe	18. Mother's Na.	me (First, Middle	, Maiden	Sumame)	7/2/034
Maryland	Mental Mental arked o	To Be	Fos	ter Ho	WARD		<u> </u>	Dar	2 Ma	el	Jood	SON
/Jan	2 sho and I		19a. Informa	ant's Name/Relationship	(Type, Print)	19b. Mailin	g Addres	s (Street and Number or Re	ural Route Numb	er, City or	Town, State, Zij	Code)
10	1 and Health Iom 27		20a. Method	I of Disposition	communica	20b. Place of Dispo			Jate .	20c. Lo	cation - City or T	own, State
ē	Pages nent of int: If it			rial 2 Cremation 3 nation 5 Other (Spec	Removal from State	Woollaw	natory of	Meters 56	5/04	Bal	HO Mi	2
Baltimore	permit. Pag Depertment Important: I any injury o			re of Funeral Service Lice		2	har	d Adors breeze	Faix	ral	Service	res
8	80 5 5 9			Va	fu drove		Yal	5 yorks	d. Ba	20/	MD 21:	212
	<u> </u>		shock,	Enter the disease, or co , or heart failure. List onl Cause (Final	y one cause on each line.	e death. Do not ente	er the mo	de of dying, such as cardia	c or respiratory a	irrest,		Approximate Interval Between Onset and Death
7	Physician /Medical		disease or o	condition	a. Due to (or as a c	onsequence of):						
	Examiner		Sequentially	/ list conditions.	b							
	pe jisi	lner	if any, leading cause. Enter Cause (Dise	y list conditions, ng to immediate a Unuarlying ease or injury	Due to (or as a c	onsequence of):						
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8760,	certificate be executed rding physician and ise as the burial-transit			•	d						-	
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Вох	thet the death cer ed by the attendin detached for use	clan	in the p	ecedent pregnant past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at time	☐Fetal death 3 ☐	Ectopic (	pregnancy specify)		2	3d. Date of deliv Month	ery Day Year
0	the d by the achec	hysi		es 21 No nknown	9□ Unknown							
S, P	w requires thet the sbeen signed by the should be detache	þ	Part II. Othe	r significant conditions	contributing to death but r	not resulting in the ur	nderlying	cause given in Part I.		tobacco u Yes 2[		the cause of death?
ord		eted							24a. Wa:			, ,
Vital Records,	40 00 01	Completed							auto perf	psy ormed?	prior to co death?	opsy findings available ompletion of cause of
ital	ian: T rtificat tor, pa	Be Co		se referred to medical				26. Place of De	1 ☐ Yes ath (Check only	2 (No one)	1 □ Yes	2 NO
of V	Physician: this certificand director,	ToB	examine 1 🗌 Yes	er?	Hospital: Impatient				T .		Other (Speci	fy)
on c	Jing P After t funera	ion:	27. Manner 1 Nati	ural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	y occurred	
Division	Attending r death.  sctor: After by the fune	ficat	2 ☐ Acc	cide 6 Could not	be 28e. Place of Injury	- At home, farm, str			28f. Location	(Street and	d Number or Rur	al Route Number,
ρ	rs after el Dire	Certification:	4 🗌 Hor	micide	building, etc. (	эреспу)			Uny or To	wn, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifie (Check one)		Physician: To the best of raminer: On the basis of examiner state	camination and/or inv	occurre vestigatio	d at the time, date and place on, in my opinion, death occ	e, and due to the urred at the time	cause(s) date and	and manner as a place, and due to	stated. to the cause(s)
	To the within !	Mec		ure and title for tifier	W			9c. License number		29d. Date	e signed (Month,	Day, Year)
	F > F 0			1000	Mosums R.	esident	A	U41764350	15124	m	y 19,	2004
	10		30. Name a	nd address of person	o completed cause of deal	th (Item 23a) (Type,	Print)	Abena Os	ei-Wus	u; D	sept I	nt Med
			31. Date file	MINIMONTH Day Year)	32. Registrar's	Signature	120					
	Sta Regist			MAY 2 5 200	4 Genera	19	1					

		-	For State Registrar	State of Maryland	•	rtment tificate				giene Rog. No. 2 [	101
Ą	Physici /Medic		1. Decedent's Name (First, Middle, Last) RIChaza,	Batchelde	2				2. Date of De Month	Day 20 2	Year 4 1 9 4 4 M
	Examir Funeral Director	er	5. Social Security Number 6. Sex	treet and number)  The EVAL HOS \$11  The All T	t birthday)Yrs.	Co/e	UM/ Year If	cation of Dea 24 Under 24 Hrs Hours Min		th ly, Year)	9. Birthplece (State or Foreign Country) California
	ס	_	Usual Residence of Decedent  10a. State 10b. County		Town or Loc	cation			10		10d. Inside City Limits 1 ☐ Yes 2 🔯 No
	h with the M 23a or 28e-f at be nutifie	Funeral Director	Md Anne Aru  10e. Street and Number  243 Federalsburg		eT	10f. Zip 0	20724			10g. Citizen of W	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-1 show other treumatic event, the Medical Examinations Exampled at	þ	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1≦Yes 2 ☐ No If Yes, Give Year or Dates:	11	Vas Decede Yes, specif	ly Cuban, I	anic Origin? ( Mexican, Pue Specify:	Specify Yes or No to Rican, etc.)	Black	o-American Indian, k, White, etc. White
21215-0036	within 72 houene. ene. then "neture	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	16a. Deced (Give I life. D	kind of work OO NOT use	Occupation during retired)	n ing most of we	orking	16b. Kind of Bus	d Space Center
Maryland 2	ould be filed wented Hygis arked other is atic event, it	To Be Co	17. Father's Name (First, Middle, Last) Noah A. Batchelde:				18		me (First, Middle e Wilkes	, Maiden Sumame	
	1 and 2 should Health and Men Iom 27 Is marke		19a. Informant's Name/Relationship (Type Ruth Batchelder-An							er, City or Town, $rac{1}{2}$	PERSONAL PROPERTY.
Baltimore,	Page nent c ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	cerr	ce of Dispos netery, crem Was1	sition (Name natory or oth h. Cre	e of her place) emato	ry 5-2	Date 5-04	Laurel,	City or Town, State  Md
Balt	permit. Departr Importe any inje	1	21. Signature of Funeral Service License	ward 401334	760	01 Sar	ndy S	pring	Rd. Lau	ral Home rel, Md	20707
10000000000000000000000000000000000000	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Precemon Due to (or as a consequent Sepsis	nce of):					100	Approximate Interval Batween Onset and Death 2 months.
,8260,	icate be executed physician and s the burial-transit	dical Examiner	if any, leading to immediate cause. E.t.sr Unionlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent		netu	ve p	uemi	They -	Disease	
P.O. Box 6	The law requires that the death certific the has been signed by the attending I bage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{ves} \ 2 \subseteq \text{No} \) 9 \( \subseteq \text{Unknown} \)	3c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3 🗆	Ectopic pre Other (spe				23d. Date Mon	e of delivery hth Day Year
	w requires that the body is the considered by should be detact	ed by Ph	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the ur	nderlying ca	use given	in Part I.		/	ibute to the cause of death?  3 Probably 4 Unknown
Il Reco		Complet	maenia.						24a. Was auto perfe 1 Yes	psy primed2 d	Nere autopsy findings available prior to completion of cause of leath?
Division of Vital Records,	Attending Physician; Thradeath. r death. sctor: Atter this certificate by the funeral director, pag	ition: To Be	25. Was case referred to medical examiner?  1		R/Outpatien 8b. Time of Injury		Other: 3c. Injury at Work?	4 Nursing		one) dence 6 Othe how injury occurre	
Divisi	ired ired	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, farm, stre	eet, factory,	office		28f. Location ( City or To	Street and Numbe wn, State)	er or Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	a andina in.		:i-	on death on	oursed at the time	data and place a	and due to the eques(s)
•	To th withir To th	Me	29b. Signature and title of certifier	ad.		29c.	License n	6034S	5	29d. Date signed 5 / 21/	Month, Day, Year)  10 4  MSLA 21044
	18,		30. Name and address of person who co	empleted cause of death (Item 2)	23a) (Type,	Print) Put	RIXX	nt /	Erkway	o Colu	msia 21044.
	St Regist	ate rar	31. Date Med Mondo, Sy. 2004	7.62. Bagistian's Signate	14	cont.			3		

			1 - For State	State of Mary		artment of rtificate or				000	1. 16550
			Registrar  1. Decedent's Name (First, Middle, La	st)		Timeate of	Death		Date of Death	1. No. 2 U U	3. Time of Death
	Physici	an	RUTH BRO						Month		ar PM
	/Medic		4a. Fecility Name (If not institution, giv			4b. Cily, Town,	or Location	of Death	MAST	\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	301
	Examir	ier	UNIVERSITY OF		EDIAL COURS		ALTIMO			N/A	
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Yea		r 24 Hrs. 8.	Date of Birth	9.	Birthplace (State or Foreign
e:	Director		218 44 6824	□M XPF 55	Yrs.	Months Day	s Hours		(Month, Day, ) 13/48	(ear)	MD.
19			Usual Residence of Decedent					Ψ/	10/10		WID.
	ylan how		10a. State 10b. County	10	c. City, Town or Lo	ocation					10d. Inside City Limits
	B-fs	toi	MD. na		BAL	TIMORE					1 ☐ Yes 2 ☐ No
	5 28 E	Director	10e. Street and Number			10f. Zip Code	)		100	. Citizen of Wha	t Country?
	15 wi	ai	1010 W. BALT	IMORE ST.	(411)	21	223			USA	
	dea dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of	Hispanic Or	rigin? (Specify	y Yes or No-		American Indian, Vhite, etc.
ထ္ထ	or it	y F.	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give X		1 □ Yes 2X N				Specify:	BLACK
ë	within 72 hours after death with the Maryland ene. Han "natural", or Itams 23e or 28e-f show ha Medical Exeminar maal be notified at	d by	3 ☐ Widowed 4 ☆ Divorced	Year or Dates:							
Ϋ́	nat	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)	(Give	dent's Usual Occ kind of work don DO NOT use retii	e during mos	st of working	16	6b. Kind of Busine	ess/Industry
2	withigh with his same.	E D	Elementary/Secondary (0-12)	College (1-4or 5+)		MEMAKE	/			ЦС	)ME
2	ther in		17. Father's Name (First, Middle, Last)	<del>_</del>	110	итинкт		ar's Name (E	irst, Middle, Ma		MIL
a	od o	Be c	SIDNEY	HESTER			10.100		ZABETI		RRIS
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If the Marylan filem 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Exeminar must be notified at	2	19a. Informant's Name/Relationship (		19h Mailir	on Address (Stree	at and Numb			City or Town, Star	
₹	d 2 s th an th an trau		ROSE MARY ROBI		1					MD. 21	, _, _,
ď,	1 an Heal Heal tem 2		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of		Date		INID . ZI	
ᅙ	Pages nent of int: If it iry or o		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer CEDAR	natory or other pi		5/26/		BROOKL	
	it. P		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fungeral Service Licer								
Ba	permit. Pages 1 an Depertment of Heal Important: If Item 2 any njury or other once.		reald	Fital		ESTEP	BROS.	FUNE	RAL HO	DME P.A MD. 21	017
			23a. Part1. Enter the disease, or com	plications that caused the							Approximate
×	Manufatan		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	_		,		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. SEROK Due to (or as a co							1 MONTH
	Examiner			VASCUL		SEASC					InvestM
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co							77000
	uted d ansit	Examiner	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a co	nsequence of):						
8760	Ine law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d							
89	tifica ng ph as th	0								note:	
ŏ	eath certific attending p	N/UR	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnan	Ci			23d. Date of	delivery
	deal	sicie	in the past 12 months? 1 ☐ Yes 2 X No	4☐ Pregnant at time 9☐ Unknown		Other (specify)	···			Month	Day Year
P.O. Box	that the de ed by the a detached t	hy	9 □Unknown								
s,	signed d be de	by Physician/M	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause g	iven in Part I	l.	23e. Did toba	co use contribut	e to the cause of death?
D C	w require been si should l							_ 4	1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
Vital Records,	e law r has be je 2 sh	Completed							24a. Was an	24b. Were	autopsy findings available to completion of cause of
ř	The I	E O							autopsy performe	d? death	10 completion of cause of 1? Yes 2 No
<u> </u>	iysician: Th	Be	25. Was case referred to medical examiner?				26. Place	e of Death (C	heck only one)		
<u> </u>	this ce al dire	Tof	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA	ther: 4□ Nu	ursing Home	5 Residence	e 6 Other (S	Specify)
Division of	ding Ph h. After th funeral	Ë	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Inju	ury at	28d.	. Describe how	injury occurred	
<u> </u>	tandit feath. tor: Ai the fu	atic	2 ☐ Accident investigation				∃Yes 2□	No			
≝	or Attanation of Attanation deal	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, stre	eet, factory, office	3	28f.	Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
	rrai or rai Dir lled in										
	Tosp 4 hou Fune ely fill	ical	(Check only 2 Medical Exan	ysician: To the best of my niner: On the basis of exa	knowledge, death	occurred at the tyestigation, in my	time, date an	nd place, and ath occurred a	due to the caus	e(s) and manner	as stated.
,	I o the nospital or Attanding Physician: within 24 hours after dealth To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	une	and manner stated.							
١	7 W.i.	-	29b. Signature and title of certifier				nse number			. Date sign <i>ed (M</i> o <i>j</i>	ontn, Day, Year)
•	~/		Dent M	L MO		AU41	76435	K14549	9	05/18	120041
	18		30. Name and address of person who				0 1				
			A MME   KILIC	27. S. C		ST.	BAL	TIMOR	t M	0	21201
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Registrar's S	Maiure Arra	a Kal					

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Man 200 Gladys Barrett /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ospita Ra 59421 050 MOI 9 If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 💢 F 217-32-9400 Yrs. Director 86 MD Usual Residenca of Decedent filed within 72 hours efter death with the Marylend Hyglene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28e-f ehov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Baltimore Dundalk MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7613 Charlesmont Road 21222 or items 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. I ☐ Yes 2 [X]No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Be Completed by Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours Department of Health end Mentel Hyglene. mportant: If Itam 27 is marked other than "naturel; 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>12 years</u> Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Zacheria Windsor Edith Northan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7613 Charlesmont Road, Dundalk, Md. 21222 <u>Jennie Barrett</u> Daughter-In-Law Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 25 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 Donation 5 □Other (Specify) 2004 Dundalk, MD. 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Fun, ral Service Licensee 23a. P. Int. Enter the distaller, or complications that caused the Jenth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7110 Sollers Point Road, Dundalk, MD. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner 0 anding physicien end use es the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? pege 2 r this cartificate haral diractor, pege 20 No 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ٩ 20 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

**DHMH 16 Rev 6/95** 

State Registrar 1101

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

00

0 -1 \$2. Registrar's Signature

1. HOITENOELL

MAY 2 5 2004

31. Date filed (Month, Day, Year)

				For State Registrar		State	of Maryl	and / Dep <i>Ce</i>	artmen ertificat	t of H e of L	ealth and f Death	Mental H	ygiene 0	04	165	52
		Dhysia		1. Decedent's Name								2. Date of E		Yeer	3. Time o	Death
4		Physici /Medio		Dehro		ardw						may	20 1	2004	9	P.M.
		Examir	ier	4e. Facility Name (III 2619 Mane	-		um <i>ber)</i>		_		Location of Death	1		nty of Deeth		
		Funeral		5. Social Security N		Sex	7. Age (In	yrs. last birthday		Jemer 1 Year			irth	timore		or Foreign
		Director		216-78-8		1 □ M 2 🟋 F		44 Yrs.	Months	Days	Hours Min.	(Month, E	19,1959	Cou ML	place (State of ntry)	ar ologn
		pu »		Usual Residence of 10a. State	Decedent 10b. County		100	City Town and								
		faryla shov	<u> </u>				100	. City, Town or L							10d. Inside C 1 ☐ Yes	ity Limits 2 ⊠No
		the N	Director	MD.  10e. Street and Nun	Baltimo	ore		Edgeme:	re 10f. Zip	Code	-		10g. Citizen o	of What Cou		
		death with the Maryland me 23e or 28e-f show ricust be notified at	0	2619 Mano	or Avenu	e				1219	)		log. Omzon	USA	nuy.	
_		death	Funeral	11. Marital Status			cedent Ever i	n U.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N	lo- 14. F	ace - Ameri		
A	9	or its	F.		ied 2□ Married	1 ☐ Yes If Yes, G	2⊠No ive		1 ☐ Yes 2		Specify:	o nican, etc.)	i	lack, White, c <i>ify:</i> Whi		
0	Ş	hours tural'	ed by	3 Widowed	4 ∐ Divorced  15. Decedent's £	Year or	Dates:	162 Dog								
•	7.	In 72	Completed		ify only highest g	rade completed		(Give	edent's Usua e kind of woi DO NOT us	rk done d se retired	ation furing most of worl )	king	16b. Kind of	Business/in	austry	
	212	d with giene.	mo	12 years		College	(1-4or 5+)	Cle	erk				Adve	rtisin	ıa	
	2	be filed within 72 hours after tal Hygiene. d other than "natural", or Its event, the Medical Examine	Bec	17. Father's Name (	171	•					18. Mother's Nam	ne (First, Middi				
7	√s		၉	Archie Cl			ne						Barret			
9	Maryland 21215-0036	d 2 sh th and 7 Is n traun	1	19a. Informant's Na Archie Bo			ather				nue, Edge				Code)	
20	ē,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other treumatic anse.		20a. Method of Disp				b. Place of Disp	osition (Nan	ne of		Date	20c. Locatio		wn, State	
11	altimore,	Pages nent of int: If it			☐Cremation 3 [ 5 ☐Other (Spec			cemetery, cře ak Lawn				24 2004	Dunda.			
3	alti	permit. Departm Departm Importal any inju		21. Signature of Ful	/	The same of the same of	1				s of Facility uneral H	24,200-	Dunda.	י עויז (אי).		
	8	89 E 8 8	1 3	744	as he	SY			/110 S	otte	rs Point	Road.	Dundall	Md.	21222	2
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5	8760,	icate be executed physician and s the burial-transit	dlcal		•	d	-									
0	9	ding p	/Me	IF FEMALE:		23c. If yes, ou	tcome of pre	onancy								
3	P.O. Box	seath atten f for u	Physician/Me	23b. Was decedent in the past 12 1 Yes 2	months?	1☐Live	birth 2 ☐ F	etal death 3	☐Ectopic pre☐Other (spe					Date of delive Month	-	/ear
	o.	t the c by the	hys	9 Unknown	140	9□ Unkr	nown									
2		es tha gned be del	by P	Part II. Other signifi	icant conditions	contributing to	leath but not	resulting in the t	ınderlying ca	use give	n in Part I.	23e. Did	tobacco use co			
2	ord	requir een si nould										1 🗆	Yes 2120No	3 🗌 Prob	ably 4 □l	Inknown
4	ec	as b	Completed			<del></del>						24a. Wa auto	psv	Were auto	psy findings npletion of c	available ause of
M	a	Prysician: The la rthis certificate a: ral director, page 2										1 ☐ Yes	ormed? 2 No	death?	2 🗆 No	
	V:t	sicial certifirecto	o Be	25. Was case referr examiner?  1 Yes 2		Hospital:	Inpatient 2	. □ <b> </b>		Otho	26. Place of Deat					
	0	g Phy er this	n: To	27. Manner of Death	1		of Injury	2 ☐ ER/Outpatie 28b. Time o		Bc. Injury Work	T I starolling inc		how injury occi	ther (Specifi urred	"	
	ion	arth. or: Aft	atlo	1 Natural 2 ☐ Accident	5 Pending investigation	on	iii, Day Fear	r) Injury	М		? 'es 2 □No					
	Division of Vital Records,	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not to determined	4   280. Plac	e of Injury - A ling, etc. (Sp	t home, farm, sl	reet, factory,	office		28f. Location City or To	(Street and Num	nber or Rura	l Route Num	ber,
		urs af urs af sral D	Ce	00- 0	<b>W</b> 0											
		24 hos	edical	29a. Certifier (Check only one)	2 ☐ Medical Exa	iminer: On the t	e best of my pasis of exam nner stated.	knowledge, deaf nination and/or in	th occurred a rvestigation,	I the time in my op	e, date and place, inion, death occur	and due to the red at the time	cause(s) and r date and place	nanner as si , and due to	ated. the cause(s	)
	_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and	title of certifier				29c.	License	number		29d. Date sign	ed (Month,	Day, Year)	
		1		> Who	nut Du	y. N	1-12		D	39	لولون		May ?	24,2	Pus	
		$\bigvee$		30. Name and addre	ess of person who	completed cau	se of death (	Item 23a) (Type,	Print)		0 115		_			
				31. Date filed (Monto	Durt Pay Vanel	75 cg	D NON	the Poi	nt 1	LU.	12014 A	nure	mo 3	11210	1	
		Sta Registr			Y 2 5 201	04	regional s Si	A April	We I		Bultin					

		•	1 - State of Maryl Registrar	land / Depa	artment of H	ealth and Me	ental Hyg	iene •g. No. 200	4 16553
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  EUGENE,		BRIDE	GES, SR.	2. Date of Deal Month	th Day Yes	
	Examir	\$	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL		BALT.	Location of Death  IMORE  If Under 24 Hrs.		4c. County of D	N/A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 215-18-0511 18 M 2 ☐ F 80 Usuel Residence of Decedent	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 13	Year) 1,1923 N	Birthplece (State or Foreign Country) [aryland
	within 72 hours after death with the Maryland ene. then "neturel", or itema 23e or 28e-f show ite Maryland Exp. virter Lust Le mellind at	ctor	10a. State 10b. County 10c Maryland Baltimore	c. City, Town or Lo	ocation	Edgeme	re		10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the	Director	10e. Street and Number		10f. Zip Code	21219		0g. Citizen of What	•
	death ma 230	Funerai	2422 Eugene Avenue  11. Marital Slatus 12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba				merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28a-f show any injury or other traumatic event, the Munical Examinational Examination at Ance.	þ	Amed Forces?  1 Never Married 2 Married  1 X Yes 2 No If Yes, Give Year or Dates:		1 Yes, specify Cuba 1 ☐ Yes 28 No		lican, etc.)	Specify: V	hite, etc. Thite
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of workin	1g	16b. Kind of Busine	
212	d withi	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 7 Years		Car Carri			Automobil Carri	e Transport er
pu	be filed ntal Hygis of other event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Sumame)	
Maryland	should ind Men ind marke umartic	2	Arvlee Bridges  19a. Informant's Name/Relationship (Type, Print) Wife	19b. Maili	ing Address (Street a			Chipley City or Town, State	a. Zip Code)
	1 and 2 s Health ar tem 27 is		Mrs. Pauline C. Bridges		2 Eugene	_		Maryland	21219
Baltimore,	of He		20a. Method of Disposition 20 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State	Ob. Place of Dispo cemetery, crea	osition (Name of matory or other place	e) Da	ate	20c. Location - City	or Town, State
Ħ	permit. Pages Department of t Important: if Ite any injury or of		' 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee		n Cemeter				ore, Maryland
Ba	Depa Impo any in		Assom E. Lea		2. Name and Addres uda-Ruck 1 922 Wise 1				Inc. 21222
S. A.S.	Physician				ter the mode of dying				Approximate Interval Between Onset and Death 3 WEEKS
	/Medical Examiner		resulting in death)  Due to (or as a con	nsequence of):					
o,	te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a condition of the cause) Due to						
68760,	cate be physicia the bu	dical	d						
P.O. Box 6	Attanding Physician: The law requires that the death certificate be executed rideath.  rideath.  sctor: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of prediction in the past 12 months? 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not	t resulting in the u	underlying cause give	en in Part I.			o to the cause of death?  Probably 46 Unknown
Division of Vital Records,	Physician: The law requiriths certificate has been rail director, page 2 should	Completed					24a. Was a autops perform 1 Yes	y prior the death	aulopsy findings available to completion of cause of ? es 2 \( \text{No} \)
Vita	sician certifu	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: Inpatient	2 C 5 B (Outro)	ot all DOA Othe	26. Place of Death			
ion of	nding Phy th. : After this e funeral d	ation: To	27. Manner of Death 1 Manuar of Death 1 Matural 5 Pending 2 Accident investigation 1 Accident investigation	2 ER/Outpatier 28b. Time o	of 28c. Injury Work	al 2		ence 6 Other (S ow injury occurred	pecity)
Divis	in Dire	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (Sp.	Al home, farm, stroecify)	reet, factory, office	21	8f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
7	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Medical (	29a. Certifier (Check only one)  // Certifying Physician: To the besi of my 2 Medical Exeminer: On the basis of examiner and manner stated.						
	To to to to to to to to to to to to to to	Σ	29b. Signature and title of certifier  P. Jalul Ett.	ERN	29c. License	17341		9d. Date signed (MC	nth, Day, Year)
	125,			S-HANIC	Print) OVER S	T. BAL	TIMO	RE, M	D 21225
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 2 5 2004  32. Registrar's S	-	only				

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar		State of N	Maryland		artment					Reg. No.	2004	16	554
	Physicia	an	Decedent's Name (F	First, Middle, Las EDWAF				BASH	OFF			2. Date of De Month MAY	21,	2004		of Death P M
	/Medic Examin		4a. Facility Name (If no	ot institution, give	street and number	or)		4b. City,	Town, or	Location o	of Death		4c.	County of Dea	th	
			1500 BEDI	FORD AVE	NUE #403						SVIL	LE _	BALTIMORE			Ε
	Funeral Director		5. Social Security Num 218–10–009	9 1	9x 7. /	Age (In yrs. I 91	ast birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours		8. Date of Bit 2/25/1	9. Birthplace (State or Foreign Country) MD			
	pur M	-	Usual Residence of De 10a. State 10	ocedent 0b. County		10c. City	, Town or Lo	ocation							10d. Inside	City Limits
	be filed within 72 hours efter death with the Maryland all tylgiene. All tylgiene death than "neturel", or itams 23a or 28e-f show ad other than "neturel", or itams 23a or 28e-f show event, the Medical Evaniner must be notified at	Director		BALTIMOR	E		ESVILL									es 🌂 No
	or 28	Dire	10e. Street and Number			_		10f. Zip						zen of What C	ountry?	
	s 23s	ral		OFORD AV	ENUE #403		6 13	212		anania Oria	ain? (Spe	cify Yes or No		S.A.	erican Indian	
"	r Itam	Ξ	11. Marital Status  1 ☐ Never Married	2 Married	Agned Force	s?		If Yes, spec	ify Cuba	n, Mexican	n, Puerto F	Rican, etc.)		Black, Whi		
93	ours e	d by	3 🕅 Widowed 4 [	Divorced	If Yes, Give Year or Date	s:		1 Yes 2	X	Specify:					HITE	
2-0	"netu	lete		5. Decedent's Ed only highest gra			16a. Dece (Give	dent's Usua kind of wor DO NOT us	I Occupa k done d	ation luning mosi	t of workir	ng	16b. Kii	nd of Business	s/Industry	
212	e filed within Il Hygiene. other then vent, the Mg	Completed	Elementary/Seconds		College (1-4d	or 5+)		RIETOF						CERY S	TORE	
Maryland 21215-0036	uld be filk Mental Hy irked oth	To Be	17. Father's Name (Fin	rst, Middle, Last)			BASH0	FF		18. Mothe	er's Name	(First, Middle		Sumame) REGOFF		
Mary	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name	e/Relationship (	Type, Print) BASHOF	F		ng Address MESTE/						Town, State, MD. 21		
	of Heali item 2 other		20a. Method of Dispos	sition	חטווטו	20b. P	lace of Disperentery, cre	osition (Nan	ne of			ate		cation - City o		
OE	00		1 Burial 2 0		Removal from Sta	ite i	IBREW	-	-		5/23	/2004	ВА	LTIMOR	E, MD	
Baltimore,	permit. Page Department Importent: It any injury o		21. Signature of Fure	Service Cider	1500									BROS. SVILLE,		208
			23a. Part1, Enter the shock, or heart f	disease, or com	plications that caus	sed the death	n. Do not en	ter the mod	e of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approxim Interval B	etween
4	Physician		Immediate Cause (Findisease or condition		2 00	mon	mia	_							Onset an	d Death
	/Medical Examiner		resulting in death)		Due to (or	as a conseq	uence of):									
L	-	er	Sequentially list condi	ediate	b. Due to (or	as a conseq	uence of):									
	be executed sicien and burial-transit	Examine	cause. Enter Underly Cause (Disease or in) that initiated events		c											
50,	e exercien ar		resulting in death) Las	st	Due to (or	as a conseq	uence of):									
8760	physic physic the b	dlcal		•	d											
O. Box 6	The law requires that the death certificate be executed ate has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2  1 9  Unknown	onths?		n 2 ☐ Feta t at time of d	Ideath 3	⊒Ectopic pr ⊒ Other (sp					4	23d. Date of do Month	elivery Day	Year
0	that the		Part II. Other significa	ant conditions	contributing to deat	h but not res	ulting in the	underlying c	ause giv	en in Part I	l.	23e. Did	tobacco u	ise contribute	lo the cause o	of death?
ecords,	w requires that been signed should be de	ed by	Pe	COLCI	3-25 0	nem	ت					10	Yes 2	<b>⊉</b> No 3□F	Probably 4 [	Unknown
Reco	The law re ate has bei page 2 sho	Completed	D	enest	ia.							perf	opsy ormed?	24b. Were a prior to death?	autopsy finding completion o	gs available f cause of
Vital		a	25. Was case referred	d to medical						26. Place	e of Death	1 Yes	one)	1010	3 2 140	
Į.	S S	To B	examiner? 1 Tes 2 No	0	Hospital: 1 Inp	atient 2	ER/Outpatie			4 L NI	ursing Hor	me 5 ⊠Res	idence	6 □Other (Sp	ecify)	
n of	ding Ph h. After th funeral		27. Manner of Death	5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		28c. Injur Wor			28d. Describe	how injur	y occurred		
Sio		icat	2 ☐ Accident 3 ☐ Suicide	investigation		Injury - At h	omo farm c	M Iront factor		Yes 2 💢		28f Location	(Street an	d Number or F	Bural Boute N	umher
Division		Certification;	4  Homicide	determined		, etc. (Specil		treet, ractory	y, onice			City or To	own, State	)	12/2//10010/11	amber,
	To the Hospitel or Attenwithin 24 hours efter deali To the Funerel Director: completely filled in by the	edical C			nysician: To the be miner: On the bas and manne	is of examina										e(s)
	To the To the To the Comple	Me	29b. Signature and tit	tle of certifier	/		1	296	c. Licens	e number			29d. Dat	te signed (Mor	nth, Day, Year	)
	~			1/ 1	1 , 5		///	2	Do	52	36	0	<	5/21	100	1 .
	18		30. Name and address	s of person who	completed cause	or doath (Iter	n 23a) (Type	Print)	a	BI	2	SA	SOF	10	(	in
			31. Date filed (Month)	CINE	ENE	gistrar's Signa	Ature	ND.	50	217	<u></u>	300	P	ESV	ut-	2/208
	St Regist	ate rar		, Day, Year) 9 5 2004		Jistrar's Signa	And the state of t	E)								

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 16555 1 - State Certificate of Death

			• Hegistrer		Heg. No.	
			1. Decedent's Name (First, Middle, Las	11)	2. Date of Death 3. Time of Death	h
	*Physici	an	Flizabatt	Krilant	Month 22 2004 13031	MG
	/Medic	al	LIIZabelh	Dryani	May 22 2004 15051	4
}	Examin	er	4a. Facility Name (If not institution, give	street and number) 4b. City, Town, or Location of Death	h 4c. County of Death	
		Ψ.	St Canos !	toolthoop   Kaltimare	1///	
		H.	J1. 1741 100 1	realth Call Daltimore	- ///	
1.0	Funeral		5. Social Security Number 6. Se		3. Distribute (State of 1 of	∌ign
	Director		216-41-0204 1	Months Days Hours Min.		1
-	Director	(	X10 10 0387		Dan. 2, 1777 Marylan	a
	P.		Usual Residence of Decedent			
	/lar		10a. State 10b. County	10c. City, Town or Location	10d. Inside City Lim	nits
	a 2	ō	$M_{i}$ , $M_{i}$ , $M_{i}$	A D. 11 :0.0.00	1 <b>X</b> Yes 2 □	No
	0 0	Director	Marylana NI	Baltimore		
	E 2	ire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
	A S		2000 Fla	1 2122G	$11 < \Delta$	
	£ 83	Funerai	3802 F10W	erion Na. 21227	4511	
	SE E	Je	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		
	je 15 15 15 15 15 15 15 15 15 15 15 15 15	13	1 ☐ Never Married 2 ☑ Married	Armed Forces? If Yes, specify Cuban, Mexican, Puèrti 1 ☐ Yes 2 Mo	to Rican, etc.) Black, White, etc.	
ജ	a o	by	/ -	If Yes, Give 1 1 Yes 2 No Specify:	Specify: DI	
21215-0036	within 72 hours after death with the Maryland one. then "neturel", or Items 23s or 28e-1 show the Mardical Examinating the notified at	P	3 Widowed 4 Divorced	Year or Dates:	Black	
P	i h	Completed	15. Decedent's Ed	ducation 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry	
5	7 5	e	(Specify only highest gra	de completed) (Give kind of work done during most of work life. DO NOT use retired)	rking	
Ċ	e e e	연	Elementary/Secondary (0-12)	College (1-4or 5+)	1 1	
7	filed wii Hygien ther th	9	12	Custodian	School	
	filed Hygid other		17. Father's Name (First, Middle, Last)	18 Mother's Nar	me (First, Middle, Maiden Sumame)	
Ĕ	tal l	Be		) // (	1 1 st, made, mader damane,	
a	ould be Mental arked c	ပ္	Charles	Soukins Sc VIV	Ian Harris	
2	should ind Men inarke umatic	_	19a Informant's Nama/Balationship /7	Type Print) [ ]	imi Bouta Number City or Tour State Tin Code)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23s or 28e-1 show other treumatic event, the Mcdcal Examinar must be notified at	11	A T T Name Helationship (7)	Type, P int) ( Husband, 19b. Mailing Address (Street and Number or Ru	arai Houte Number, City or Town, State, 2ip Code)	
2	12 and 12		IVIr James	Bryant 3802 Flowerton	n Kd Kalta Md. 212:	29
a)	1 and Health em 27 ther tr		20a. Method of Disposition		Date, 20c. Location - City or Town, State	~ ]
5	2 to 1 to 2		1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of Disposition (Name of cemetery, crematory or other place)	200. Education - City of Town, State	
Baltimore,			'4 □Donation 5 □ Other (Specify		2/120011 A-6. +. ~ MA	
₽		1 N		THE DUIL STREET	TIDULUSIVIA	1
a	permit. Departr Importe eny inje		21. Signature of Funeral Servite Licen:	10 ( )   Trank	Fire a a 1 Harris	
$\mathbf{m}$	89 = 89	117	the sound	A CHILDY BOSEPH KINGST	Tuneral Trine	
			HOUSE	1 JULY 12222 W. NOTTH A	ve. parto ina vialo	
			23a. Part If Enter the disease, or comp shook, or heart failure. List only of	plications that caused the death. Do not enter the mode of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between	
			Immediate Cause (Final		/ Onset and Death	
<b>)</b>	Physician		disease or condition	a Caronary Anterioscleratic	Poscular Misease Unknow	M
	/Medical		resulting in death)	Due to (or as a consequence of):	// // // // // // // // // // // // //	
	Examiner					
4			Sequentially list conditions.	b		
		Jer	Sequentially list conditions, if any, leading to immediate	b		
	ted nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
<u> </u>	ecuted and transit	caminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  c.		
°,	executed an and rial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
,09	be executed sician and burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  c.		
8760,	cate be executed oblysician and the burial-transit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):  c.		
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State

Registrar

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Bryant, Elizabeth @

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		1 - For State Registrar	Otato of Maryland		tificate of			10 0 2 No.2	+ 16556
		Decedent's Name (First, Middle, La	st)				2. Date of Dea	th	3. Time of Death
Physi /Med		Mary A. Brewer					Month May 21	Day Year 2004	8:20 A M
Exam		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of De		4c. County of De	
		Stella Maris				nium		Baltimo	
Funera		5. Social Security Number 6. S	I M 2 ME	ast birthday) Yrs.	If Under 1 Yea Months Days		n. (Month, Day		inhplace (State or Foreign Country)
Directo	r	215-01 -4474  Usual Residence of Decedent	99	115.			0ct. 13	3, 1904 L	ithuania
land ow		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Man,	ģ	Maryland N/A		Baltim	ore				1XXYes 2 □ No
h the	Director	10e. Street and Number		<u> </u>	10f. Zip Code			log. Citizen of What	Country?
23e c		4504 Simms Ave	nue		212			U.S.A.	
r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Y	Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
s afte	Y F	1 ☐ Never Married 2 ☐ Married  3 ▼ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♥ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: TJ	hite
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. Ith and Mental Hygiene. Ith is marked other then "neturel", or Items 23e or 28e-f show treumetic event, I'm Modical Examiner must be nufficed at	Completed by	15. Decedent's E		16a. Dece	dent's Usual Occi	upation		16b. Kind of Busines	
715 in 72 n "ne	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give life.	kind of work don DO NOT use retir	e during most of w ed)	vorking		,
d with dispense in the	E	8th. Grade	College (1740/37)						
Ind 21215-U be filed within 72 ho tal Hygiene. d other then "netur event, Ire Madical	Be	17. Father's Name (First, Middle, Last	)			18. Mother's N	ame (First, Middle,	Maiden Sumame)	
arylan should be ind Mental s marked o	10	Anthony Bartu	sewicz			Kazimi		Murauska	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumetic		19a. Informant's Name/Relationship (		19b. Mailir	ng Address (Stree	et and Number or i	Rural Route Numbe	r, City or Town, State	, Zip Code)
and and lealth m 27		JamesM. Geise			Simms A	lvenue	Baltimon Date	e MD 21 20c. Location - City of	206
Baltimore, permit. Pages 1 ar Department of Hea Importent: If item;		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from State	metery, crer	natory or other pl	' !		20c. Location - City o	or rown, State
ti Pa rimer rimer rient		' 4 □ Donation 5 □ Other (Special 21. Sign where of Funeral Service Lice	KIAII		f Faith		24/2004	Baltimor	e MD
Baltimo permit. Pag Department Importent: I	ouce	21. Signature of Puneral Selvice Lice	Do nail	3/	Mille	er-Dippel	Funeral	Home, Inc	• 01006
		23a. Part 1. Enter the disease, or come shock, or heart failure. List only	nplications that caused the death	. Do not ent					21206 Approximate Interval Between
	J	Immediate Cause (Final							Interval Between Onset and Death
Priysicia /Medica		disease or condition resulting in death)	a. CONGESTIVE  Due to (or as a consequ		FAILURE				
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100	je 🚾	Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury	b. Due to (or as a consequ	ence of):					
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IS, P	y P.	Part II. Other significant conditions	contributing to death but not resu	lting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records, he law requires t e has been signe tge 2 should be							1 U Y	es 2□No 3□I	Probably 4 Munknown
aw re	piet						24a. Was a		autopsy findings available
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	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or		
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Division of I or Attending Phy after death. Director: After this I in by the funeral d		27. Manner of Death  1   Natural  5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	ork?	28d. Describe h	ow injury occurred	
Vision  Attending or death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	006 Leasting (C	2	Own I Power Manager
is pitted	Certification:	4 Homicide determined			eet, factory, office	9	City or Tow	treet and Number or i n, State)	nurai noute Number,
pitel purs a erel I		29a. Certifier 1X Certifying P	hysician: To the best of my know	wledge deatl	n occurred at the	time, date and pla	ce and due to the c	ause(s) and manner	as stated
Div To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in b	Medical		miner: On the basis of examinat and manner stated.						
Fo the within Fo the	Me	29b. Signature and title of certifier			29c. Licer	nse number	2	9d. Date signed (Mo	nth, Day, Year)
,- ,- 0		) /n.			DL	13725			
1	0	30. Name and address of person who	completed cause of death (Item	23а) (Туре,					
	*	DR. TARIQ MAHMO			LEY RD.	TIMONI	JM, MD 210	093	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure /	als				
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MAY 21, 2004

MARY BREWER

State of Maryland / Department of Health and Mental Hygiene 2004 16557 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BAZEMORE 10:21 AM **Physician** CLAUDIA MODENER 2004 MAY /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22 WALDEN POPLAR CT. WOODLAWN BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-3-1938 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours NORTH CAROLINA 1□M 27 F 237-62-6532 65 Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show rai', or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No BALTIMORE WOODLAWN Director MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 22 WALDEN CT. USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after I ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 2☐ No Specify Specify: <u>م</u> BLACK 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than HOUSEWIFE HOMECARE 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any jury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) Be WALTER PARKER MARY COOPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) THOMAS M. BAZEMORE (HUSBAND) 22 WALDEN CT. WOODLAWN, MARYLAND 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 □ Removal from State KING MEMORIAL PARK 5-26-2004 BALTIMORE, MARYLAND 5 Other (Specify) \* 4 □ Donation D. HIBNERName and Address of Facility MAJOR H. WINFIELD FUNERAL HOME 21. Signature of JONATHAN Funeral Service Licensee 704 N. FRONT ST. STEELTON, PENNA 17113 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ships or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Artenvaclerotic carchorasullar obserse **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of) the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has or Attending Physician: 25. Was case referred to medical examiner?

1 ★ Yes 2 □ No filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Do00 7632 MAY 20, 2004 Lindran Curtan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print MD BALTO 21222 . CROSSAN O YONOVAN DUNDALK AVE MP 2112 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 5 2004 Registrar

04-03338 RKD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death . Decedent's Name (First, Middle, Last) Month **Physician** 17, 2004 12:40P. MAY SANFORD WILLIAM BARKSDALE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. N/A 613 N.WOODINGTON ROAD 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 XM 2 ☐ F Yrs. Director 6-29-1942 MARYLAND 219-38-9944 61 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10h County item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Madical Examiner must be notified at 1 Yes 2 No MD. Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 613 N. WOODINGTON RD. USA deeth v by Funeral permit. Pages 1 and 2 should be illed within 72 hours after dee. Department of Heelih and Mental Hygiene. importent: if item 27 is marked other thermany injury or other treummit 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) -12--0-RIGGER LEADER COAST GUARD 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM BARKSDALE VIRGINIA BALLARD ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NADINE OUTLAW-MOORE (DAUGHTER) 3313 VIRGINIA AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State <sup>4</sup> □ Donation 5. Other (Specity) GARRISON FOREST VETERANS OWINGS MILLS MARYLAND Services License TONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of F 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician ATHEROSCIEKOTIC CARDIOVACCULAR HYPERTENSIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): DISEASE **Examiner** Sequentially list conditions, it any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a punsionismos offi-Physician/Medical Examiner The law requires that the death certificate be executed physiclen end s the burial-transit Due to (or as a consequence of): P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown HEPATITIS, BRAIN INFARCTS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 1 XYes 2 □ No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCHNE ġ 2 1 XYes 2 No his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Lues O.C.M.E. MAY 18,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 200 is Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May 19, 7:30 p. Russell Allen Chalker A.K.A. Russell Chalke 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** North Arundel Hospital Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 24, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpface (State or Foreign
Country) **Funeral** XXM 2 F 53 Yrs. Feb. Director 1951 Maryland <u>217-62-939</u>2 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 1 Yes XXNo Maryland Anne Arundel Glen Burnie Direct 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 918 Blakistone Road 21060 America οf Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXXNo ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after XXNever Married 2 Married Saltimore, Maryland 21215-0036 1 Yes XXNo þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 2 Elementary/Secondary (0-12) Dispatcher Air Frieght injury or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hient: If Item 27 is marked others. Be L. Allen Chalker, Jr. Elizabeth Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21060 Elizabeth N. Chalker (Mother) 918 Blakistone Road; 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 24, permit. Page Department o Importent: If any injury or once. Mav \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Metro Crematory Catonsville, Maryland 21. Ignatur of Funer Samuel Lis has 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 23a. Lett. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on lach fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed -tran and physician a Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes Physician: funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 4 Nursing Home 27 No 1 Yes\_ 2 ER/Outpatient 3 DOA 2 1 Inpatient 5 Residence 6 Other (Specify) After this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: Injury at Work? Hospitel or Attending 1 Natural 2 Accident 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeref Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated the 29b. Signa/ure Date signed (Month, Day, Year, 30.1 32. Registrar's Signature 31. Date fifed (Month, Day, Year) State MAY 2 5 2004 Registrar

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			1- State Registrar Certificate of Death	Reg. No.2 0 0 4	16560
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	Physic /Medi		Gwendolyn Ruth Wark	May 21 200	1 1:02H,M
	Examir	ner	4a. Facility Name (If not institution, give streat and number)  4b. City, Town, or Location of Death  Towson	4c. County of Dea	moRG
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth 9. Bir	thplace (State or Foreign
	Director		235-46-3143 1 70 Yrs.	8-18-33 Nei	WJERSEY
-	/land		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
600	Maryland	ctor	MD BALTIMORE TOWSON		1 Yes 2 No
Ci	with the	Funeral Director	10e. Street and Number	10g. Citizen of What Co	ountry?
7	death v	erai	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	erican Indian,
Ja	6 after c or iter	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes, Give If Yes, Specify Cuban, Mexican, Puerlo  1 □ Yes 2 □ No Specify:		e, etc.
	<b>21215-0036</b> O/O2 so within 72 hours after death with the Marylar giene. er then "natural", or items 23a or 28e-1 show t, the Medical Examinar must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:	Specify: W	かった・
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5	Z 5 € 5 €		Gloria Biebl- friend 1039A Donington (	ircle Towson	MD
avendolyn	altimore, M mit. Pages 1 and 2 partment of Health portent: if item 27 1 y injury or other tre		1 Burial 2 Cremation 3 Removal from State	Date 20c. Location - City or	Town, State
Ž	Baltimor Dermit. Pages Department of Importent: if it any injury or o		4 Donation 5 Other (Specify) EVANS FUNERAL CHOPPEL 5 - 2	11-04 FORESTH	Ich, mo
B	Ball permit Depart Import any in		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23.25 YORK  FINCE OF ACTERNATIVE  23.25 YORK	(RD, TIMENIUM M.	D 21093
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure List only one cause on each lige.	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Concer		Onset and Death
	/Medical Examiner	ŀ	Due to (or as a consequence of):		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):		
	cuted nd ransit	Examiner	that initiated events		
	760, te be executed ysician and ne burial-transit		resulting in death) Last Due to (or as a consequence of):		
	ys e	dicai	d		
	Box (eath certif	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of de	livery
	Records, P.O. Box 68 The law requires that the death certifica te has been signed by the attending ph nage 2 should be detached for use as th	Physician/Med	in the past 12 months?  1	Month	Day Year
	P.O. hat the de sd by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
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X	aw rec	Completed			utopsy findings available completion of cause of
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	Of Phys	7: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Residence 6 Other (Spe 28d. Describe how injury occurred	city/CSPICE
	anding ath. or: After	ation	1  Natural 5  Pending (Month, Day Year) Injury Work? 2  Accident investigation M 1 Yes 2 No		
	Division of Vital Records, to Attending Physicien: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be discounted.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ric City or Town, State)	ural Route Number,
	Spitel ours a nerei C	al Ce	29a. Certifier	and due to the cause(s) and manner as	s stated.
	Division of Vita To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical	(Check only and Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
	To ti To ti	Σ	29b. Signature and title of certifier  29c. License number	29d. Date signed (Mont	
			20 Name and address of passes who completed eauto of death (fam 22a) Type Print)	MAY 212	004
	り		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Autom J. Challesino 6601 N Challes St Beatt work at	10 21204	
		ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature		
	Regist	rar	MAY 2 5 2004 Beneva & Smiles		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2004 adi /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Aberd If Under 1 Year 74 38 toro 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Bountry) **Funeral** Days Hours Min 1 M 2 F 9 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 128 21001 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. or Items 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify. 3 Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WORK el a other 17. Father's Name (First, Middle, Last) 18. Mgther's Name (First, Middle, Maiden Sumame) ... Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 Is marked off jury or other traumatic even warc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is nany injury or other traum 20b. Place of Disposition (Name of cemetery, cremators 128 deen 20a. Method of Disposition
1 Burial 2 A Cremation Date 20c. Location - City or Town, State 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) FORE 21. Signature of Funeral Service Licensee DR., FORESTHILL, MD 22. Name and Address of Facility 3 NEW PORT 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician yemon' /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner physician and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After s after dec. 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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DHMH 17 Rev 1/2001

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Registra

MAY 2 5 2004

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 16562 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $\frac{\text{Month}}{5/22/04}$ Year OSCAR P. CHASE 5:30A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death

7. Age (In yrs. last birthday)

10c. City, Town or Location

85

HANOVER

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

A.A.CO

45 FURNACE BRANCH Rd GIEN BURNE Md 21060

29d. Date signed (Month, Day, Year)

8. Date of Birth (Month, Day, Year)

9/19/18

Birthplece (State or Foreign Country)

MD

10d. Inside City Limits

Yes 2□No

**Physician** /Medical Examiner

(HOME) 7514 RIDGE RD.

10b. County

6 Sex

5. Social Security Number

10a. State

217 18 0247

Usual Residence of Decedent

**Funeral** Director

"neturel", or items 23a or 28a-f show solical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

burial-transit

Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifie

RUBEN

MAY 2 5 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

to	MD. A.	A.CO	HA	NOVER						X Ye	9s 2 1	
lrec	10e. Street and Number			10f.	Zip Cod	В		10g. Ci	tizen of What Cou	ntry?		
E O	7514 RIDGE	RD			21	076			USA			
ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13. Was De	cedent o	of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No	)-	14. Race - Ameri Black, White			
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marr		] No	1 ☐ Yes						BLACK	ζ	
eted	15. Decedent (Specify only highes	's Education t grade completed)	16a.	Decedent's U	sual Oc	cupation ne during most of w	orking	16b. K	(ind of Business/Ir	ndustry		
omply	Elementary/Secondary (0-12)	College (1-4c	r 5+) E	NGINE	Tuse re	(BOILER		FT.	. GEORGE	MEAI	ÞΕ	
O	17. Father's Name (First, Middle,	Last)				18. Mother's Na	ame (First, Middle	, Maider	n Sumame)			
To B	JAMES F.	CHASE				I	ILLY L	. CI	IASE			
	19a. Informant's Name/Relations CARROLL CHA					eet and Number or F E RD. HA		er, City o		o Code)		
	20a. Method of Disposition  1 → Burial 2 → Cremation  4 → Donation 5 → Other (S)		te cemete	f Disposition (in the control of the	orother	V.A. 5/2	Date 28 / 04		ocation - City or T		MD.	
	21. Signature of Funeral Service	**			and Ad	dress of Facility	•		Æ. P <sub>2</sub> A2			
	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caus only one cause on each	line.	not enter the r	node of	tying, such as cardi	ac or respiratory a	rrest,		Approxima Interval Be Onset and	etween d Death	
	Immediate Cause (Final disease or condition resulting in death)  a. ACUTE CEREBRO YASOULAR ACCIDENT  Due to (or as a consequence of):  Sequentially list conditions.											
		Due to (or	as a consequence	(01): CarseR1	1 /	250 10	TERING	0	nSi/	10 Uz	=10	
ē	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequence	of):	FU	ECU ITA	1 610000	-	75	1000	413	
ᇤ	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .							1			
cal Exa	resulting in death) Last	Due to (or	as a consequence	of):								
ledi												
sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death	3 Ectopi 5 Other					23d. Date of deliv Month	ory Day	Year	
Phy	Part II. Other significant condition	Nas contabuting to death	but not resulting	n the underlyin	n cause	given in Part I	23e Did	obacco	use contribute to	the cause of	f death?	
ed by		TENSION	, but not rooming	The disconying	9 04430	groot it at t		Yes 2	_		<b>⊴</b> Unknov	
Completed by Physician/Medical Examiner						· · · · · ·	24a. Was auto perfo 1 🗆 Yes	psy omed?	death?	ompletion of	s availat	
Be (	25. Was case referred to medical examiner?						eath (Check only	опе)				
To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	itient 2 ER/Ou	utpatient 3	DUA		Home 5 Resi	dence	6 ☐Other (Speci	ty)		
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 32b. Time of Injury 4 Work? 1 Yes 2 No									iry occurred			
ertifica	3 Suicide 6 Could determ	100d   200. Flace U	Injury - At home, fa etc. (Specify)	arm, street, fac	tory, off	се		Street and Number or Rural Route Number, wn, State)				
Medical Certification:		g Physicien: To the be Examiner: On the basis and manner	of examination ar								9(S)	
Ne	29h Signature and title of certifier // 29c, License number 29d, Date signed (Month, C									Dav. Year)	)	

DHMH 17 Rev 1/2001

State Registrar

DOS 04-033	65	unț	end iter#23a,27,28a-f,F Please T	ER ME,G833,7/21/ Type or Print in E	04eg Black in	delible ink	. Ensure A	All Copie	s Are	Legible.		
Lorrai	ne Cal	lov	Vay For 1 State Registrar	State of Marylar	id / Depa		Health and I			e 2001	169	563
	Dhysisi	-	Decedent's Name (First, Middle, Last)					2. Date of D	eath Da	y Year	3. Time of	Death
	Physici /Medio		Lorraine Louise	Callaway				May 1		2004	556	a <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give				or Location of Deat	n -	40	. County of Death		
3	458		Union Memorial H				timore	-1		N/A		
366	Funeral Director		5. Social Security Number 6. Security Number 218-76-2458		last birthday) 6 Yrs.	If Under 1 Year Months Days		8. Date of B	Day, Year 196	9. Birthp Cour Mar	place (State of htry) yland	r Foreign
	death with the Maryland ims 23a or 28a-f show r o dat be notified at	tor	10a. State 10b. County Maryland N/A	10c. Ci	by, Town or Lo Balti					1	10d. Inside Cit	
	th with the 23a or 28	al Director	10e. Street and Number 1017 W. 36th Stree	t		10f. Zip Code	21211		10g. Ci	itizen of What Cour US		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show are intry or other traumatic event, If a Medical Examination and be notified at any futury or other traumatic event, If a Medical Examination and be notified at ance.	by Funeral	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes <b>X2</b> No If Yes, Give Year or Dates:	'	Was Decedent of If Yes, specify Cut 1 Yes 2 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	lo-	14. Race - Americ Black, White, Specify: W		
õ	ture ettre	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	pation		16b. k	Kind of Business/In-	dustry	
Maryland 21215-0036	ad within 72 rgiene. er than "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12) 11th	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire memaker	during most of wor	rking		In Own H	•	
yland	buld be file Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Martin Hoffman					Almond				
, Mar	and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (Ty Richard Callaway,	Sr. Husband	9 Ha	ylock Ct	tand Number or Ru . Apt. 30	ral Route Num 02 Knot	ber, City Cting	or Town, State, Zip gham, MD	21236	
Baltimore,	Pages 1 nent of He tnt: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 A Termation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	Iomaval from Ctata	cemetery, crei	esition (Name of matory or other pla e-Washin	gton 5/24	Date / 2004		ocation - City or To		
Balti	permit. Departr Imports any inju		21. Signatur Theral Service License		22	Name and Addr Burgee 3631 F	ess of Facility -Henss-Se alls Road	itz Fur Balti	eral more	Home, I	nc. 11	
	/Medical Examiner price of the	dicai Examiner	23 Part1. Enter the disease, or complete strock, or heart tentire. List only on the strock, or heart tentire. List only on the strock, or heart tentire. List only on the strock of the	Due to (or as a consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (or a) consect Due to (	alprazi	zolam and	d alcohol	intoxi	cati	on	Approximate Interval Betv Onset and D	veen )eath
Division of Vital Records, P.O. Box 68760	Attanding Physiclen: The law requires that the death certificate be e rideath.  rideath.  ector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burier.	ıysiclan/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	ıl death 3□	Ectopic pregnanc Other (specify)	гу			23d. Date of delive Month	-	'ear
ds, P.	luires that the signed by a detaction	d by Physic	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause g	ven in Part I.			use contribute to th		
Il Reco	The law requireate has been spage 2 should	Completed						per	s an opsy formed? 2 \( \subseteq \text{No.}	death?	psy findings a mpletion of ca 2 \( \text{No} \)	available ause of
/Its	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	th Check onl	one			
of.	Physi this o	2	1 X 163 2 □ 140		ER/Outpatier	IL SLXDON				6 Other (Specify	y)	
n c	Jing F	lon	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 5/19/04	28b. Time of Injury 5:30			28d. Describe		ry occurred		
<u>isi</u>	ttend death. tor: /	Icat	2 Accident investigation 3 Suicide 6 X Could not be				Yes XXNo	unknown		ad Alumbas as Oum	1 Davida Alcond	
Div	in Diffe	Certification;	4  Homicide determined	28e. Place of Injury - At h building, etc. (Special found in house				1019 W.	36th	Street, Bal	Ltimore,	
	Hospital 24 hours a Funerel I stely filled	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ition and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time	e cause(s , date an	) and manner as st d place, and due to	ated. the cause(s)	J
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Da	ite signed (Month,	Day, Year)	
			Jacka?	41000	110	OCMI				y 19, 200		
· t	10)		20 Name and address of severe with a	ampleted cause of boat (ter-	/VV)	Print)						
O MONT	2		Tashor Z. Grooss	Month Michigan	) )	111 Pe	enn Stree	t, Balt	imor	e, Maryla	and 212	201
Bougange	Sta Registi		31. Date filed (Month, Day, Year)  MAY 2 5 2004	32. Registrar's Signa		rocks!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Year MMY Zo 0914 /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of peath HEAILH Care gnes bultimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Gountry) Maryland **Funeral** Days 217-20-7944 1 □ M 2 0 F Yrs. Director Usual Residence of Decedent 10a. State 10b. County works ! 10c. City, Town or Location 10d. Inside City Limits r than "natural, or Itams 23a or 28a-f show the Medical Examinat must be notified at 1XYes 2 No Director Marylana more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3600 2 d 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) other 7 le marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nie Dat 0 ivenia 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) net. W. 10.21229 360 6 Talk other 0 altimore, 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ö ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee oseph North 23a. Part. Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician atheroscleratic Cardiovascular discos unknum /Medical Due to (or as a consequence of): Examiner diabetes unteren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner inding physicien and use as the burial-transit hupettasz Due to (o as a consequence of): perknoz1 MKHENN The law requires that the death certificate be exec resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been signe should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 20 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy perform 2 **X**No 1 ☐ Yas 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 200 Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Inpatient 2VZ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral 6 To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 33081

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 2 5 2004

Healthcare Baltimore

ame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			State of Mary  1 - State Registrar AMEND ITEM #17& 30 PER FH G					201	04 165	CE
			Registrar 1111 #170 30 FFR FIT 30     Decedent's Name (First, Middle, Last)	331 3/23/6	HIDICALE OF	Jean	2. Date of Death	1	3. Time of D	eath D
	Physicia /Medic		NATALIE		CUTLER		MAY 20,	<sup>Day</sup> 2004	12:22	Рм
	Examin		4a. Fecility Name (If not institution, give street and number)	T1 1 F	4b. City, Town, or	Location of Death		4c. County of	NAME OF TAXABLE PARTY.	
	Funaval		BRIGHTON GARDENS OF PIKESV  5. Social Security Number 6. Sex 7. Age (In	ILLE n yrs. last birthda	y) If Under 1 Year	PIKESVI If Under 24 Hrs.	8 Date of Birth		BALTIMORE  9. Birthplace (State or F	Foreian
	Funeral Director		021-26-9210 1□M 2 <b>X</b> F	69 Yrs.	Months Days	Hours Min.	DEC. 1, To	34	9. Birthplace (State or F Country) MASS	i .
	and and a		Usuel Residence of Decedent           10a. State         10b. County         10	c. City, Town or	Location				10d. Inside City	Limits
	Mary a-f sho	tor	MD BALTIMORE	PIK	ESVILLE				1 ☐ Yes 2	≥ X No
	or 284	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	,	
	death with the Maryland ims 23a or 28a-f show finant be notified at		1840 REISTERSTOWN ROAD  11 Marital Status 12. Was Decedent Ever	rin II C 12	Was Decedest of H	21208	posity Voc er No	14 Page	U.S.A.	
9	alter death with the Marylan or Items 23a or 28a-f show init of Trust be notified at	Funeral	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1410.3.	Was Decedent of H		o Rican, etc.)		, White, etc.	
5-003	72 hours after natural', or ite	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify:	WHITE	
-51	within 72 ene. than *nat	piete	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occup re kind of work done o DO NOT use retired	during most of wor	rking	6b. Kind of Busi	iness/Industry	
2121	filed with Hygiene other tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CON.	TRACTS ANA	LYST		J.S. DEF	PT. OF JUST	ICE
Maryland	be d al	Be	17. Father's Name (First, Middle, Last)	MYE	nc .	18. Mother's Nan	ne (First, Middle, M	laiden Sumame,	GOVERMAN	
Ž	s 1 and 2 should be f Heelth and Mental item 27 is marked o other treumatic eve	ဥ	BERNARD BEN JAMIN MYERS  19a. Informant's Name/Relationship (Type, Print)		iling Address (Street			City or Town, Si		
	and 2 eelth a n 27 is eer treu		MARK CUTLER / SON	6 B	ELLADONNA	COURT -	OWINGS M	ILLS, ME	21117	
altimore,	0 0 = =		1 Burial 2 X Cremation 3 Removal from State	cemetery, ci	position (Name of rematory or other place				City or Town, State	
<u>=</u>	permit. Pag Depertment important: I any injury o		*4 □ Donation 5 □ Other (Specify) ☐  21. Signature of Funeral Service Licensee / / / /		SERVICE CO	1		TOWSON,		
Ba	permit. Depertrimports any inju		Sixt M. Withe		22. Name and Addre				.E, MD 2120	8
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.						Approximate Interval Betwe	een
	Physician		Immediate Cause (Final disease or condition resulting in death)	retory	Faclur				Onset and De	ath
	/Medical Examiner		Due to (or is a co	onsequence 4):	Land On in	Clarend			4 mm	es.
		ner	cause. Enter Underlying	onsaguenne of):	Leno car	an -			4 mon	4.0
	ecuted and I-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or las a co	il Ho	lemocor	unne			++ nu	ntr
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9		Medi	IF FEMALE:							
Вох	death certiti e ettending od tor use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	☐Ectopic pregnancy			23d. Date Mont	of delivery h Day Yea	ar
o.	0 0	hysic	1 Yes 2 No 9 Unknown 9 Unknown	o or doain - S	Citiel (specily)					
s, D	res that the de igned by the e be detached t	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause giv	en in Part I.			oute to the cause of dea	
ord	w require been signature						1 🗆 Ye	s 2 1 No 3	Probably 4 Uni	known
Records,	has has	Completed					24a. Was an autopsy perform	pri led? de	ere autopsy findings av ior to completion of cau ath?	ailable use of
a		0	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 ath (Check only one		Yes 2□No	
> <	G S. X	To B		2 ER/Outpati		4 Linvursing H	lome 5 ☐ Resider			
ono	ding Ph h. After th tuneral	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Ye	28b. Time lnjury	Wor	yat k? Yes 2 □ No	28d. Describe how	w injury occurred	t	
Division of Vital	r Attender death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	- At home, farm,			28f. Location (Str. City or Town,	eet and Number	r or Rural Route Numbe	∋ <i>r</i> ,
	itel or irs efter ral Dir led in									
	To the Hospitel or Attending within 24 hours efter death.  To the Funeral Director: Atter completely filled in by the tuner	edical	29a. Certifier  (Check only one)  2 Medical Exeminer: On the basis of exemple one and manner stated.	amination and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occu	, and due to the ca irred at the time, da	use(s) and manr te and place, an	ner as stated. Id due to the cause(s)	
	To the within To the comple	Med	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (	(Month, Day, Year)	
	7		William 1. M= 1	cure à	no Di	680,		MAY	21, 2009	<i>#</i>
	10		30. Name and address of person who completed cause of death	Jan 1982		11713877777	A/D			
	Sta	te	WILLIAM P MAGUIRE, III BRIGHON GAI  31. Date filed (Month, Day, Year)  32. Registrar's	Signature	1	TVLOATITE*	MU.			
	Registr		MAY 2 5 2004 Separa	19	Sporks					

DHMH 17 Rev 1/2001

ORIGINAL

		ŀ	1- State of Maryland / Department of Health and N Certificate of Death	R	leg. No 2 D D J	16566
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  WILBUR VERNON COATES	2. Date of Dear Month	Day Year 23 2004	3. Time of Death O
	Examir	eı	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  BALTIMORE VA MEDICAL CENTER  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 M 2 F  78 Yrs.  78 Yrs.	8. Date of Birth		
	Director		218-18-8953	SEPT. 1		MD  Od. Inside City Limits
	the Maryla 28e-f sho	Director	MD         NA         BALTIMORE           10e, Street and Number         10f, Zip Code		log. Citizen of What Coun	1 X Yes 2 □ No
5-0036	be filed within 72 hours efter death with the Maryland nat Hygiene. do other than "netural", or items 23a or 28e-1 show event, it e Madiral Examiner must be natified at	by Funerai	719 N. EDGEWOOD STREET  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education  21229  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Named Forces. 1 Never Named Forces. 1 Never Named Forces. 1 Never	pecify Yes or No- Rican, etc.)	USA  14. Race - America Black, White, e Specify: AFRI	an Indian, itc. CAN ICAN
1215	withIn 72 ene. then "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  (Give kind of work done during most of work life. DO NOT use retired)  WHOLESALE DISTRIE			•
Maryland 21215-0036	id be filed vental Hygie ked other to cevent, IL	Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam  CITABLE S. COATES	e (First, Middle, I	GROCERY Maiden Sumame)	
lary	2 should be and Mental ie marked eumatic ev	J.	CHARLES COATES  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run			Code)
	1 and dealth em 27 ther tr	12	SHIRLEY E. COATES (WIFE)  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State		IMORE MD 2 20c. Location - City or Tor	1229 wn, State
Baltimore,	permit. Pages Department of H Importent: If ite any injury or of		21. Signature of Funeral Service 122. Name and Address of Facility	YLIE FU	OWINGS MILLS NERAL HOME P LTIMORE, MD	
	Pnysician /Medical Examiner		23a Page Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CORONARY ARTERY DISEASE  Due to (or as a consequence of):  Sequentially list conditions,  b.	or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	icate be executed physiclan and sthe burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
P.O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of deliver Month	y Day Year
	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DIABETES		bacco use contribute to the	
Vital Records,	The law ate has b page 2 sl	Completed		24a. Was a autops perform	sy prior to con med? death?	sy findings available apletion of cause of
Vita	sician: certific rector,	o Be (	25. Was case referred to medical examiner?  Hospital: Cher.			
of	ding h. After fune	-	1 Yes 2 No   No   No   No   No   No   No   No		ence 6 Other (Specify ow injury occurred	)
Division	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	treet and Number or Rural n, State)	Route Number,
1	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	dicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cared at the time, d	ause(s) and manner as sta late and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	ŀ	29d. Date signed (Month, L	*
	1)		And Yoy MD  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		MAY 23	2004
	V		10H. Green St	BACTOR	nD 21201	
	Sta Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  MAY 2 5 2004  P 1 7 999  10 N. Greene St			

		-	For State Registrar	State of Marylar	nd / Department of F Certificate of		lental Hygiene Reg. No	
	Physicia	an	Decedent's Name (First, Middle, Last)     AR	LVN DA	MOGERFIEL	D	2. Date of Death Month Da	3. Time of Death 7 2004 4:30 8. M
•	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number) N STREET	4b. City, Towns o	AUTIMOK		c. County of Death
	Funeral Director		719. 49.4221	M 2 1 7. Age (in yrs.	last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year	9. Birthplace (State or Foreign MAL)/LAND
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  M.D.		ty, Town or Location AUTIMORE			10d. Inside City Limits 1 ■ Yes 2 □ No
	3a or 28e	Funeral Director	10e. Street and Number 336 KOSSIETE	0	10f. Zip Code	21212	10g. Ci	itizen of What Country? U.S.A.
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Madical Examinar mast be notified at	þ		2. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1.S. 13. Was Decedent of lift Yes, specify Cub 1 Yes 2 17 No	lispanic Origin? (Spi an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: DLACK
21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "natural, or Items 23s or 28s-f show other then "natural Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use paire	during most of work.	ing	Kind of Business/Industry HEACTHCARE
Maryland 2	should be filed withir and Mental Hygiene. I marked other then umatic event, Ine M	To Be C	17. Father's Name (First, Middle, Last) BENJALMIN	DUBOSE			e (First, Middle, Maide EUA 7	n Sumame) EMPLE
	nd 2 state are trau		NOVELLA D. DUB	bose MOTHER		Th BAU	, more, M	D 21215
Baltimore,	permit. Pages 1 ar Department of Hea Important: if Item any injury or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	emoval from State GR	Place of Disposition (Name of cometery, crematory or other place EEN MUNT CREM	DOTORY 5.2	27.04 BA	Location - City or Town, State  UTIMORE MARYLAND  REFUE FINERAL HITTER  MARYLAND 21212
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or dompli shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deale cause on each line.  Due to (or as a conse	-RESPIRA	ng, such as cardiac		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consec				
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic pregnanc	у		23d. Date of delivery  Month Day Year
rds, P	es tha	by	Part II. Other significant conditions con	atributing to death but not re	sulting in the underlying cause gr	ven in Part I.		use contribute to the cause of death?  2 Ao 3 Probably 4 Unknown
of Vital Record	The law ate has b page 2 s	Completed		-			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 No
Vita	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	lospital:	05		h (Check only one)	. 50.0
	Phys this ral di	. To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Inju	ary at	ome 5 Residence 28d. Describe how inju	
Division	or Attending I after death. Director: After	Certification:	1 Autural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Yéar)	Injury Wo	ork? ]Yes 2□No	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
_	dospitel	edical Ce	29a. Certifier (Check only one)  29a. Certifying Physical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death occurred at the tation and/or investigation, in my	ime, date and place, opinion, death occur	and due to the cause( red at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To the lawithin 2. To the formula complete	Me	29b. Signature and title of Certifler	Elella	29c. Licen	se number		ate signed (Month, Day, Year)
	, ,		30. Name and address of person who co	ompleted cause of death (Ite	5 OSLER 1	PIVE	TOWSON	0 21204
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	D Spart			

			State of Manuand / Don	artment of Health and Mental Hygiene
				rtificate of Death Reg. No. 2004 1656
	Physic	ian	Decedent's Name (First, Middle, Last)	2. Date of Death  Month Day Year  3. Time of Death
	/Medi	cal	SHIRLEY ANN DULIN	MAY 21 2004 5:50 P <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL	4b. City, Town, or Location of Death FREDERICK FREDERICK FREDERICK
	Funeral	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9 Birtholace (State or Foreign
	Director		267-82-0149 10M 20F 54 Yrs.	Months Days Hours Min. (Month, Day, Year) Country FLOALIA
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation 10d. Inside City Limits
	Mary a-f eh	tor	Md. FREDERICK FREDE	FRICK 1 Pres 2 No
	or 28s	irec	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	ath w	ral	1301 DANBERRY (OUR)	21703 USA
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "neturel", or items 23a or 28a-1 show other treumatic event, the Medical Evan's activistics modified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
036	urs af	by	3 Widowed 4 Divorced   Types 2 No   1 Market   1 Yes 2 No Specify:	
215-0036	72 ho netur Jical	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation  If the Company of the Comp
121	vithin ne. hen	mple	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)  (LERK  U.S. Gov T.
d 21	filed with Hygiene. Ither the		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
a	lid be lental ked o ic eve	To Be	WILLIE SIMMENS	PEARL HORNE
Maryland	2 should and Men is marke sumatic	-		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 Health a em 27 is ther tre	8	Josh E. Dulin, JR. (Husband) 19b. Mail Josh E. Dulin, JR. (Husband) 1301	
ore	0 0 = =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of Date 20c. Location - City or Town, State
Baltimore			'4 □Donation 5 □Other (Specify)	n. PARK NORTH 5-28-04 Miam, FLORdia
Ba	permit. Departr Importe any inju			2. Name and Address of Facility GARY L. ROLLING FUNEARL HOME
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac or respiratory arrest,  Approximate
1	Physician	Ø	Shock, or real tailure. List only one cause on each line.	Interval Between
7	/Medical		disease or condition resulting in death)  a	- Mikity india
	Examiner	L	Sequentially list conditions, b. CARI	DIO My of ATHY Years
W	led sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	512 = 105121
<u> </u>	s be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):	EVET ENSION YEARS
760,	te be ex ysician ne burial	cal	D 1A	BETES 11 PCALS
99	(D) ====	Physician/Medi	IF FEMALE:	
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy 23d. Date of delivery Month Day Year
	that the de led by the a detached	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify) Month Day Year
	The law requires that the tee has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	w requires l been signe should be		Khameteid Authoris	1 ☐ Yes 2 2 No 3 ☐ Probabiy 4 ☐ Unknown
900	e law requ has been je 2 shoul	ompleted	Rand Diales, Status - 7	24a. Was an 24b. Were autopsy findings available
= H		Соп	Periphoral Varcular Disease	autopsy prior to completion of cause of performed? death?  1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
of Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
of	Phys this ral dii	. To	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time o	
ion	Attending Ph ir death. ector: After thi by the funeral	ation	1- ✓ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work?  M 1 □ Yes 2 □ No
Division	f or Attendi after death. Director: A	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	eet, factory, office 28f. Location (Street and Number or Rural Route Number,
Ö	itel or A rrs after rel Dire	O	3, 56, (255,17)	City or Town, State)
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	2 I Medical Examiner. On the basis of examination and/or in	occurred at the time, date and place, and due to the cause(s) and manner as stated.  /estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Mec	one) and manner stated.  29b. Signature and kitle of centrier	29c. License number Mary and 29d. Date signed (Month, Day, Year)
	->-0		Markey MI)	D0047556 05 23 04
	41		30 Name and address of person who completed cause of death (Item 23a) (Type,	Print) 2/702
	011			2 THOMAS JOITNSON DRIVE, TUZENEWICK, MD
<b>:</b> ·	Sta Registra		31. Date filed (Month, Day, Year)  32. Registrar's Signature	
DHN	MH 17 Rev 1/20		MAY 2 5 2004 Senera &	Spark
			ORIGINA	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DOBSDEN 1022 M EARL D. MANY 4a. Facility Name (If not institution, give street and purposer) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 18700 WACKERS CHOKE CHITHER'S BULL Mouracycry if Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 8. Date of Birth (Month, Day, Year)
August 10,1940

9. Birthplace (State or Foreign Country)
New Jersey 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F Director 162-32-6567 63 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic avent, the Marical Examiner and the maillied at once. 1 ☐ Yes 2 🙀 No Directo Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18700 Walker's Choice Road 20886 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Amed Folces:
1 XYes 2 No
If Yes, Give
Year or Dates: Vietnam 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: \$ Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Merchandiser Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Eric Dresden Marguerite Brunswick 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail D. Parker/Sister 16709 Baederwood Lane; Derwood, MD 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Crematory 05/21/2004 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, MD 20852 with 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHOUSINGT WOUND TO HEAD Physician /Medical Due to (or as a consequence of): Examiner surcios Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ned by the attending physical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗆 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes I or Attending Physicien: after death, Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 No 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Ascribe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 1 Natural 5 Pending SELF INFLETTE GUNSHOT WOULD 18 ray 1 ☐ Yes 2 No N COPO M investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18700 WHOMA ONOR DO, GHYPPHINE To the Hospital within 24 hours a To the Funeral C 29a, Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only \*\*Sedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier (M.O.) DWE 19 15236 my 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IIINS ROCKLING PRICES PECKLINE , MO C0859 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 5 2004 Registrar

		State     Registrar  1. Decedent's Name (First, Middle, Last)		Certific	cate of L	Death	2. Date of Dea	eg. No. 20	04 65		
Physicia /Medica Examine		Just:	Month Day Year								
		4a. Facility Name (If not institution, give s			City, Town, or	Location of Death	May	4c. County			
Ladiiiii	iei	2406 Kays Mill R		Fink	sburg		Carroll				
Funeral		5. Social Security Number 6. Sex		Mor	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day June 10	Year)	9. Birthplace (State or F Country) Maryland		
Director		217–21–6719 IA	M 2□F 18	Yrs.	July 5	110410	June 10	,1985	Maryland		
72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Examiner must be multilled at		10a. State 10b. County	10c. City, Tov	wn or Location	n				10d. Inside City		
	tor	Maryland Carroll				1 Tyes 2					
	Dire	10e. Street and Number 2406 Kays Mill Rd		10	Y. Zip Code 210 <sup>L</sup>	18	1	0g. Citizen of W	/hat Country?		
ns 23	era	-	2. Was Decedent Ever in U.S.	as Decedent of Hispanic Origin? (Specify Yes or No- res, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian,				
s aftar de	Completed by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		es 200 No		Rican, etc.)	Blac	Black, White, etc.  Specify: White		
2 hou sturs cal E	ted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin, life. DO NOT use retired)						16b. Kind of Bu	siness/Industry		
ithin / le. lan "n	nple	Elementary/Secondary (0-12)	urig	~							
led w lygien her th	Co	12	19 Mother's Nam	o (First Middle		School					
be file	Be	17. Father's Name (First, Middle, Last)					Beth Pat		9)		
should nd Me mark matic	2	Richard Alan Dors 19a. Informant's Name/Relationship (Ty)		b. Mailing Add	dress (Street a	and Number or Rui			State, Zip Code)		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant. The Medical Examinat must be multiped at once.		Richard Dorsey -		_		Rd. Fin					
		20a. Method of Disposition	20b. Place	of Disposition	(Name of y or other place	e)	Date	20c. Location -	City or Town, State		
		1 ☐Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Everg	reen Me	em. Gar	dens May	27,2004	Finks	sburg, Md.		
		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Eckhardt Funeral Chapel P.A.									
20 E 2 9		J. Neik telle	<u> </u>	1160	5 Reist	erstown	Rd. Owir	gs Mill	s, Md. 2111		
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do e cause on each line.	not enter the	mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Betwe Onset and De		
hysician		Immediate Cause (Final disease or condition resulting in death)  a. Astrocytoma (Brain tumor)									
/Medical Examiner		Due to (or as a consequence of):									
	ē	Sequentially list conditions, if any, leading to immediate  b. Tuberous sclerosis  Due to (or as a consequence of):							18 yea		
d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):									
te be execut ysician and ie burial-trar	EX										
ate be hysici the bu	Physiclan/Medical										
death certificate be executed e attending physician and d for use as the burial-transit		IF FEMALE:	To If you guitage of progressor								
attend for us		in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death		pic pregnancy er (specify)			23d. Date Mor	e of delivery hth Day Yea		
the the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	3 🗆 🗸	or (apochy)						
res that the igned by be detact	by Ph	Part II. Other significant conditions cor	tributing to death but not resulting	in the underly	ying cause give	en in Part I.	23e. Did to	oacco use contr	ibute to the cause of dea		
To the Hospital or Attanding Physician: The law requires that within 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detained.	q p						1 □ Y	s 2½ No	3 ☐ Probably 4 ☐ Uni		
	Completed						24a. Was a	n 24b. V	Vere autopsy findings av		
	HO						perfori	ned?   d	leath?		
	Be	25. Was case referred to medical examiner?			Othe		h (Check only or	7.	**		
	2	1 ☐ Yes 2 ☐ No	ome 5 Residence 6 □Other (Specify)								
	lon:	27. Manner of Death 1 Natural 5 Pending	28d. Describe hi	e how injury occurred							
	icat	2 Accident investigation 3 Suicide 6 Could not be	28f. Location (Street and Number or Rural Route Number,								
	Certification:	4 Homicide  5 Homicide  4 Homicide  5 Homicide  4 Homicide  5 Homicide  5 Homicide  6 Homicide  7 Homicide  8 Homi									
	ledical C	29a. Certifier  (Check only (Check only 2) Medical Examiner: On they basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner (Check only 2) Medical Examiner: On they basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and									
the I	Medi	29b. Signature and title of certifier)  29c. License number									
5 1 Ki									29d. Date signed (Month, Day, Year)  May 25, 2004		
0	1	30. New and accuracy of person who co	THE TOTAL OF COSTS (No. 200	W H	2	439	-	may .	23, 2004		
()		30. Name and accress of person who co						_	J		
17		John S. Ignato	wski, M.D., 69	O Poo	ole Rd	., West	minster	, MD 2	1157		

	•	For State C	of Marylan		rtment of H			Reg	ene 20	04 16571			
Physicia /Medica Examine		1. Decedent's Name (First, Middle, Last)  ROBERT JOSEPH DEBRO  4a. Facility Name (If not institution, give street and not institution)  Control of the contr	umber) HOS	pital	4b City, Town, or	ma	of Death	2. Date of Death	4c. County of				
Funeral Director		5. Social Security Number 6. Sex 245-86-6348 1 ★★ 2 ☐ F	7. Age (In yrs. I	ast birthday) _ Yrs.	Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, 7/6/1954	Year)	9. Birthplece (State or Foreign Country) NORTH CAROLINA			
land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Loc	ation					10d. Inside City Limits			
e Mary	ctor	MD BALTIMORE		BALTII					1 ☐ Yes 2 XXNo				
with the	Dire	10e. Street and Number 3815 WEST COLD SPRING LANE			10f. Zip Code	215		10	g. Citizen of Wt USA	nat Country?			
urs a	by Funeral Director	11. Marital Status 12. Was Dec Armed F	2 <b>XX</b> No	If Yes, specify Cuban, Mexican, Puerto Rican,					Specify: BLACK				
be filed within 72 ho tal Hygiene. d other than "natur event, Ital Musical	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	) (1-4or 5+)	(Give A	ent's Usual Occupa kind of work done of OO NOT use retired LABOR	ation during mos )	ng 1	16b. Kind of Business/Industry  AGR I CULTURE					
e d la	To Be Co	17. Father's Name (First, Middle, Last)  WILLIAM HENRY DEBREAUX						(First, Middle, M		)			
2 should and N is main		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
permit. Pages 1 and 2 should Department of Health and Mel Important: If item 27 is market any injury or other traumatic once.	1 3	JOSEPHINE WHITEHEAD  20a. Method of Disposition  1XXBurial 2 Cremation 3XXRemoval from  4 Donation 5 Other (Specify)	State C	lace of Dispos emetery, crem	sition (Name of natory or other place	-		ate 2	0c. Location - C	City or Town, State			
permit. P Departme Importar any injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARYLAND MORTUARY SUPPORT											
Physician		23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death  Approximate Interval Between Onset and Death											
w requires that the death certificate be executed  been signed by the attending physicien and should be detached for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that infitated events	o (or as a conseq	uence of):									
The law requires that the death certificate be executed are has been signed by the attending physicien and bage 2 should be detached for use as the burral-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year				
w requires that been signed by should be deta	ρλ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Munknown				
25. 20	Completed								24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No				
Physician: Tribis certifical	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Oth	00		n (Check anly one		r (Specify)			
ng Phy fter this	atlon: To	27. Mannar of Death  1 Natural 5 Pending 2 Accident investigation	28b. Time of Injury	b. Time of 28c. Injury at 28d. Describe					p how injury occurred				
tal or Attending rs after death. al Director: Afte ed in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Pla bui	<del>(</del> y)	eet, factory, office			City or Town	(Street end Number or Rural Route Number, งพก, State)					
To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	edical		he best of my kno basis of examina anner stated.	owledge, death ation and/or in	occurred at the tirvestigation, in my o	pinion, de	nd place, ath occurr	ed at the time, da	ite and place, a	nner as stated. nd due to the cause(s)  (Month, Day, Year)			
To with To com	W	29b. Signature and title of certifier		m 23a) (Type,	80	14	99	<b>L</b>	5/i	7/04 1 Hospital			
Sta Registr		31. Date filed (Month, Day, Year) 32 MAY 2 5 2004	Registrar's Sign	ature	2)	1410	VIIC			1 1.05/1136			

	1 - For Stete Registrer  1. Decedent's Name (First		State of I	viaryian		artment of H tificate of I		2. Date of De	Reg. No.	200	4 165 3. Time of Deat	
Physician /Medical Examiner	Patricia L.	Dicker		er)		4b. City, Town, or Baltin	Location of Dea	Month May	21 4c. 0	County of Dea		
uneral rector	5. Social Security Number 219–28–5340	) 10	м <b>эДх</b> F 7.	Age (In yrs. 70	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	933 Ma	rthplace (State or Fore ountry) ryland	
be notified at		. County		10c. Cit	y, Town or Lo Baltin				10a Citiz	zen of What C	10d. Inside City Lin 1XXYes 2☐	
23a or 2 al be o		4428 La Plata Avenue					21211 USA					
marked other than *natural*, or ttems 23e or 28a-f show imatic event, the Medical Examinational De resiliad at To Be Completed by Funeral Director	3 ☑ Widowed 4 🗆 I	2 Married	2. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	as? [X]No		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2☑ No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		4. Race - Am Black, Whi Specify:		
ner than "nature it, the Medical E Completed	15. I (Specify on Elementary/Secondary	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Doce (Give kind of work don life. DO NOT use retirementary/Secondary (0-12)  Homemaker						one during most of working atired)				
atic event, To Be C	Andrew	-						18. Mother's Name (First, Middle, Maiden Sumame) Genevieve M. Schneider				
ra la	19a. Informant's Name/F Dale Dicker		Son			ng Address <i>(Street a</i> La Plata						
ant: If item 2	20a. Method of Disposition  1XXIII 2 Cre  4 Donation  5	emation 3 Re	emoval from St	ate La	Place of Dispo cemetery, crem ake Vie	sition (Name of natory or other place W Memoria	al 5/2	Date 4/2004		rsburg	r Town, State , Maryland	
Importent: If II any injury or c	21. Signature Funeral	Service License	3. X/c	nss		Name and Address urgee—Her 631 Falls		z Funera Baltimor	1 Hor	me, Inc	. 21211	
sician edical	23a. Part1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition resulting in death)	ure. List only one	Enclo	andit	h. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death	
physician and stress to burial-transit.	Sequentially list condition of any, leading to immedicate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sequentially is conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events  Cause (Disease or injury that initiated events								40 hours		
do by the attending letached for use a letached for use a Physiclan/Me	IF FEMALE: 23b. Was decedent pregin the past 12 monin 1	ths?	1 Live birth 2 Fetal death 3 Lectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							Month	f. Date of delivery  Month Day Year  contribute to the cause of death	
should should		· · · · · ·	1 ☐ Yes						s an	24b. Were autopsy findings availa		
cate has page 2								1 Yes	ormed? 20 No	death?		
tor: After this certificate the funeral director, pag catlon; To Be Co	examiner?	Pending investigation	Ospital: 1 Impatient 2 ER/Outpatient 3 DOA Dither: 4 Nursing Home 5 Residence 6 Other (Specify)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2 No							ecify)		
led in by Certifi		4 ☐ Homicide determined building, etc. (Specify)					City or Town, State					
he Fune pletely fil edical										is stated. le to the cause(s)		
To th compl	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  29d. Date signed (Month,  21d. 23d. 24d. 25d. 25d. 25d. 25d. 25d. 25d. 25d. 25								ath, Day, Year)			
State Registrar	Catherine Mc	sonler,	Union 32. Reg	Memor	igl; a	parks	versity	Parkw	oy; I	Baltimo	ore MD, 21	

Michael Scott 04-03392	: D	enmyer Please Ty and Item#23a,27,28a-f,PER	pe or Prir	nt in Bla	ck Ind	lelible In	ık. E	insure A	All Copies	Are	Legib!e.		
RJ		1 - For State Registrar	State of Mi	arylariu .		tificate o			vietilai i iy	Reg. No	CUU5	16573	
Dhamini		Decedent's Name (First, Middle, Last)							2. Date of De Month	eath Day	y Year	3. Time of Death	
Physici /Medic		Michael Scott	Denmyer			# 63 T			May 20		004 County of Deal	0745 A. M	
Examir	er	4a. Facility Name (If not institution, give st 20205 Downes Road	reet and number)			4b. City, Town		cation of Deatr	1		•	County	
Funeral		5. Social Security Number 6. Sex		e (In yrs. last	birthday)	If Under 1 Ye	ar If	Under 24 Hrs.	8. Date of Bir (Month, Da	rth.		hplace (State or Foreign	
Director		212-17-3273	M 2□F	24	Yrs.	WOTHING DA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		May 20	, 198	80 MI		
iand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Lir		
Many Refeh	ctor	MD Baltimore Parkton    10e. Street and Number   10f. Zip Code   10g. Citi   20208 Downes Road   21120   1   11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   1 Never Married 2 Married   1 Yes 2 No   1							1 ☐ Yes 2 🔀				
d 21215-0036 Illed within 72 hours after death with the Maryland Hygiene. thar then "natural", or Hems 23a or 28a-f show int, the Medical Examinate mat by mailified at	Dire	10e. Street and Number 10f. Zip Code 10g. C							tizen of What Co	ountry?			
eath weath w	erai	20208 Downes Road  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Marmed Forces?)  14. Marital Status  15. Was Decedent of Hispanic Origin? (Specify Yes or No-Marmed Forces?)								USA 14. Race - Ame	nican Indian,		
6 after d	Fun	11. Marital Status 1. Married 1.	Armed Forces? 1 ☐ Yes 2 🛣			Yes, specify C □ Yes 2 🔯 1		llexican, Puert Decify:	o Rican, etc.)		Black, Whit		
21215-0036 Id within 72 hours afi giene. ar then "natural", or at the Madical Exam	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:									White	
15-0	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							rking	16b. K	ind of Business	Industry	
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nd on the control of	Bec	17. Father's Name (First, Middle, Last)					18.	. Mother's Nan	ne (First, Middle	, Maider	Sumame)	_	
Maryland Id 2 should be file th and Mental Hy Z7 is marked oth traumatic avanti	10	Walter Albert Denm			10h Mailine	Address /Str			a Dawn (			Zin Codo)	
Mar d 2 sh th and th and traum		19a. Informant's Name/Relationship (Typ			:C288Ast E8	9/108-501				00000		21p C000)	
than than		Walter A. Denmyer 20a. Method of Disposition		20h Plac	a of Disnos	B Down it ition (Name of atory or other i	f	May	arkton, Date 26	20c. Lo	ocation - City or	Town, State	
imor Pages nent of I		1 N Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	moval from State	Dula:	ney V. rial	atory or other palley Gardens	<b>s</b>	20			Timoniu	n, MD	
Baltimore, permit. Pages 1 at Indopertment of Hee Important: If item any injury or othe once.		21. Signature of Funeral Service Lisensee			22. Le	Name and Admmon Fu	dress of	f Facility a1 Hom	e of Dui	lane	y Valle	, Inc.	
m gozad		23a. Part Enter the disease, or complic			<u>le 10</u>	W. Pac	<u>doni</u>	a Road	Timon	lum,	MD 210	Approximate	
		shock, or heart failure. List only one Immediate Cause (Final	cause on each li	ne.			-, -, -,					Interval Between Onset and Death	
Priysician /Medical		disease or condition resulting in death)	_ Heroin I Due to (or as				_						
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vision of Vital Records, P.O. Box 6876( Attanding Physician: The law requires that the death certificate be releath. sctor: After this certificate has been signed by the attending physicia squor; After this certificate has been signed by the strenging physicia	by P	Part II. Other significant conditions cont	ributing to death b	out not resulting	ng in the un	derlying cause	given in	n Part I.		tobacco i Yes 2		o the cause of death?	
cord  requir been si	eted										322		
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Vital Relician: The Lector, page	e Co	25. Was case referred to medical					26	Place of Dea	th (Check only		1 Yes	2 🗆 No	
f Vita ysician: is certific	To B	examiner?	ospital: 1 🔲 Inpatie	ent 2□ER	VOutpatient	3□ DOA	Othor		lome 5 ☐ Resi		6 🔀 ther (Spe	cify) Scene	
On O ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 Pending (Mante Par Year) Work?							28d. Describe		ry occurred	17	
Division  I or Attanding after death. Director: After Jin by the fune	icati	2 Accident investigation 3 Suicide 6 2 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Locatic									nd Number or Ri	ural Route Number	
in I fee	Certification;	3 ☐ Suicide 4 ☐ Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  4 ☐ Homicide  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)											
Di To tha Hospital or within 24 hours aft To tha Funaral Dir completely filled in	dical C	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best	of my knowle	edge, death	occurred at the	e time, c	date and place	, and due to the	cause(s	and manner as	stated.	
SO H ST ST ST ST ST ST ST ST ST ST ST ST ST									ined at the time,		te signed (Mont		
29b. Signature and title of certifier						296. 00	ense nu O	CME			21, 200		
		30. Name and address of person who cor	mpleted caps of o	death (Item 23	3a) (Type, F	(m)1 D~	on C	troot	Raltim	nre	Marrylar	rd 21201	
		PAR CIA ACALGA- COLLAR MA											
	ate	31. Date filed (Month, Day, Year) MAY 2 5 2004	3 Registr	rar's Signatur	April 1	de)							
Regist	al	MAI A J LOO.	1		•								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () 1 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day ROBERT **ERDMAN** MAY 20, 2004 12:45 P.M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death N/A RICHEY HOSPICE JOSEPH BALTIMORE 8. Date of Birth (Month, Day, Year) 10-13-1920 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex Months Days Hours Yrs. 216-12-9988 83 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 21/2No WOODLAWN BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6711 WINDSOR MILL ROAD 21207 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 100 No ff Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married XX Married 1 ☐ Yes 2XXNo Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) KNIPP COMPANY College (1-4or 5+) Elementary/Secondary (0-12) CABINETMAKER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRY **ERDMAN VIOLET** AMENDT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARCELLA L. ERDMAN 6711 WINDSOR MILL ROAD, WOODLAWN, MARYLAND, 21207 (WIFE) 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-22-2004 TOWSON, MARYLAND, 21204 HILLTOP SERVICE CORP. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death DIEGOIG Immediate Cause (Final disease or condition resulting in death) MONM STAGG (CND) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown ZZAM 1 ☐ Yes 2 ☐ No ABDOMINAL 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2Z No 1 Yes 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Adatural 2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

P.O. Box 68760, of Vital Records, Division after death Director: / e Funerel D letely filled in

Physician

/Medical

Examiner

**Funeral** 

**Director** 

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items 23e or 28e-f ehov nero uni be notified at

item 27 is marked other then "neturel", or items other treumatic event, the Medical Examiner.

d 2 should be filed within 7 th and Mental Hygiene.

permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 is
any injury or other treu.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

Directo

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Completed

Be

Physician/Medical IF FEMALE: ģ Completed Be 2 Certification:

in the past 12 months?
1 Yes 2 No 9 Unknown

25. Was case referred to medical examiner? 1 🗌 Yes

5 Pending investigation

1 ☐ Yes 2 ☐ No

N- CHANCES SF, ADIO, DATIMONEY MAZIZOY

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 | Homicide

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 29b. Signature app

Medical

3 🗌 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

forsicion 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

tille of certifier

0055532

SANTARY 31. Date filed (Month, Day, Year)

MAY 2:5 2004

32. Registrar's Signature

MD

State Registrar DHMH 17 Rev 1/2001

within 2. To the F

6565

			1 = For State Registrar	State of Maryland	Department of He Certificate of D			ene 1. No 2001	16575
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last,	FILES	4b. City, Town, or Lo		2. Date of Death Month MA-Y	Day Yea 20 200 4c. County of De	4 13.25 P M
	Funeral	iei	GOOD SAMAR 5. Social Security Number 6. Sec	ITAN HOSPITI	AL BALT	more	B. Date of Birth (Month, Day, Y		irthplace (State or Foreign
	Director		Usual Residence of Decedent  10a. State  10b. County	À	own or Location		10.11.1	912 30	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-1 show finual be notified at	Director	10e. Street and Number		TIMOLE  101. Zip Code		10g	. Citizen of What	Α΄
9		Funeral		12. Was Decedent Eyer in U.S. Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,		ify Yes or No- ican, etc.)	U · S 14. Race · An Black, Wr	nerican Indian, nite, etc.
15-0036	in 72 hours after s "natural", or ite	Completed by	3 Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grade)		1 ☐ Yes 2 ☑ No  6a. Decedent's Usual Occupation (Give kind of work done during life. DO NDT use retired)	Specify: on ring most of working	7 16	Specify: L. b. Kind of Busines	S/Industry
nd 2121	be filed within tal Hygiene. d other than "	Be Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Domes	STIC 8. Mother's Name (		DRIVA	HE
Maryland		ToB	19a. Informant's Name/Relationship (Ty	10 RRIS SR. pe, Print),	9b. Mailing Addrass (Street and	FANNIE	MAE	HEND	
a)	is 1 and 2 should of Health and Mer Itam 27 is marke other traumatic		20a. Method of Disposition	EY DAVETHIER 3	3617 ACAMED of Disposition (Name of tery, crematory or other place)	DA CIRC	LE BA	CTIMILE, c. Location - City of	MD 2/2/8
Baltimor	permit Page Department of Important: If any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License  Uwww.	MARYL	AND NATIONAL	of Facility VAUC	HN C	GREENE	MARYLAND FUNELAL HOME LYLAND 21212
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Decause on each line.  Due to (or as a consequence)	ROLAC A	such as cardiac or r	espiratory arrest		Approximate Interval Between Onset and Death
	Examiner is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (in as a consequence	RI AVIE	Ky 1)	1 JEAS!		10
8760,	ate be executed hysician and he burial-transit	cal	that intitated events resulting in death) Last	Due to (or as a consequence		ROSII			30
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	elivery Day Year
Records, P.	w requires that been signed by should be deta	ρ	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in	in Part I.			to the cause of death?
		Completed					24a. Was an autopsy performed	death?	utopsy findings available completion of cause of s 2 No
of Vital	Physicial this certif al directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No H		Outpatient 3 OA Other:	5. Place of Death (C	5 🗌 Residence		ecify)
Division of	Attending Physician: It death. ector: After this certific. by the funeral director.	Certification:	1	(Month, Day Year)		2 🗆 No	Describe how i		
2	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		I	City or Town, S.	tate)	ural Route Number,
	tha Hos hin 24 ho the Fun npletely i	Medical	one)	ician: To the best of my knowledger: On the basis of examination a and manner stated.	and/or investigation, in my opinio	on, death occurred	at the time, date	and place, and du	e to the cause(s)
	To To To		29b. Signature and title of certifier	1 11	D 3	1280	29d.	Date signed (Mon	th, Day, Year)
	り		30. Name and address of person who con	10 -	(Type, Print) 55	601 Loc Bultimor	h Ran	in Bl	rd 20
*	Star Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	South	1100	)		3/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.ZUI Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 8:18 A M Mai 2004 Gordon Ford 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sinai Baltimore Baltimore Hospital of If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 59 10/19/1944 212-44-4809 South Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location "naturel", or Items 23e or 28e-f show adical Examiner must be profifted at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2611 West Coldspring Lane U.S.A. 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □No 1965

If Yes, Give Year or Dates: 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XNever Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced other treumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Is marked other then 4 Laborer Dept. Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f ment of Health and Mental I Gilbert Ford Estelle Rosborough 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Desadra D. Ford / Daughter 321 N. Calhoun St., Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If eny injury or once. Metro Crematory Inc. 05/25/2004 Haltimore, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Sign ure of Funeral Service Licen 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage **Physician** Renal End disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** egene vanulomatosic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-transit or Attending Physicien: The law requires that the death certificate be executed 1 Devtensi Due to (dr as a consequence of) P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed 1 Yes 2 1 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA his nours after death.

nerel Director: After this

filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

completely

To the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tonya Mason, 31. Date filed (Month, Day, Year)

MAY 2 5 2004

taron

(Check only one)

29b. Signature and title of certified

MD 2401 West 32. Registrar's Signature

Belvedere Ave Baltimore

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0056418

29d. Date signed (Month, Day, Year)

21

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May

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		Examine		4a Fecility Neme	'If not institution	n, give st	reet end nu	imber)	1			4b. City, Town, o	,	4c.	County	of Deeth		
				5. Social Security I	All	HO	Spi	7. Age (In	vrs last hi	rthdevi	f Under 1 Year		MOTE	lirth		9 Rinth	nlace (Sta	te or Foreign
		Funeral Director		214-54- Usuel Residence of	4661	*D	M 2□ F		55		fonths Days		n. (Month, I		49	Cou	MD	ite or Foreign
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10	ore,	of Health of Health litem 27 i	1	20a. Method of Dis	position			20	b. Place o	f Disposition	on (Neme of ory or other pla		Date			- City or T		
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	Baltimore,	permit. Pag Department Important: I any injury o		21. Signaturé of E	uneral Service	Licensee	las	1		Mar	ame and Addre		, Balt	imore	e M	ıd 2	2121	5
			T	23a. Part 1. Enter shock, or hea	the diseese, or art failure. List	complic only one	tions that	caused the deach line.	death. Do	not enter t	he mode of dyin	ng, such as cardi	ac or respiratory	arrest,			Approxi	mate Between
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Ì	T	Medical . Examiner		Immediate Cause disease or condition resulting in death)	on	a.	a	rebr	Carre	mon	T acc	ident				1	30	minutes
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	O. E	e dea the att	300	Part II. Other signi	ficant condition	ns contr	ibuting to d	eath but not	resulting i	n the unde	rlying cause giv	ven in Part I.	23b. DI	d tobacco i	use co	ntribute t	o the cau	se of death?
K	σ.	Attending Physician: The lew requiras that the death cer redeath. sctor. After this certificate has been signed by the attendin by the funaral director, page 2 should be detached for use	be completed by Physiciany										1[	Yes 2	No	3 ☐ Pro	bably 4	Unknown
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	S	after Dire	Ę	4 🗌 Homicide	determ	li lou	build	ing, etc. <i>(Sp</i>	ecify)		•		City or T	own, State)				
		To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as tha bunial-transit	medical Certification; 10	29a. Certifier (Check only one)			r: On the b					me, date end place opinion, death occ						se(s)
		To the comp	Σ	29b. Signature and	title of certified	70					29c. Licens			29d. Date	signe	d (Month,	Day, Yea	r)
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		1		30. Name end edd	ress of person	who com	pleted caus	se of deetb	Item 23e)	(Type, Prir	nt)	) <	, i'a i A i	1-1	1		110	/
		State		31. Dete filed (Mor	nth, Day, Year)	pn	32. F	Registrer's Si	igneture	1	0,11	1 /	110171		U.	26	1 17	-
		Registra	7		Y 2 5 20	04	Sel	ava	B	de	souls	,				۷		

DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:00Pm REEMAN KAYMOND TORPH TRO 4a. Fecility Name, (If not institution, give street end number) /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 24 Hrs. 8. Date of Hours Min. Bultimore MARYLand Masonic Homes If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F **Funeral** Days Months 212-01-6499 Yrs. Director Usual Residence of Decedent permit. Peges 1 end 2 should be filled within 72 hours after death with the Marylend Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumstic event, it a Medical Examinat must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Cockeysville Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code USA 21030 300 International Cir. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Law Attorney 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katherine Mary Ellen Dunn Horace Joseph Freeman ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 209<u>0</u>6 Leona H. Vincent/Daughter Apt. 1A Silver Spring, 3500 Forest Edge Dr. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date May 22 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State Woodlawn Cemetery 2004 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 21. Signature of Funeral Service 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Michael Timonium, MD 21093 Flagle 10 W. Padonia Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Tes 2 No 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3□ DOA Certification: To

been signed by the attending physician end should be deteched for use es the buriel-trensit Division of Vital Records, P.O. Box 68760, funeral director, page 2 should be efter death. | Director: After this certificete | filled in by To the Hospital o within 24 hours of To the Funerel Di

Baltimore, Maryland 21215-0020

27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

(Check only

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the bests of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

D21464

29b. Signeture and title of certifie

29d. Date signed (Month, Day, Yeer) 29c. License number

mpleted cause of death (Item 23a) (Type, Print)

MO.

Ballo, Rul 21224

State Registrar

Medicai

31. Date filed (Month, Day, Yeer) MAY 2 5 2004 32. Registrar's Signature

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Barch

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Physician GOVER 200L /Medical 0 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 200 TURECAPE HOMEWOOD BALTIMORE 5. Social Security Number 2141828 25
Usual Residence of Decedent If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) Funeral Year) Months Days Hours Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or items 23e MON 21218 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes, 2 W No If Yes, Give Year or Dates: JER 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours effer nent of Heelth and Mente! Hyglene. int: If Nem 27 Is marked other than "naturel", or he 1 ☐ Yes No **Maryland 21215-0020** Specify: Š Specify: WHT 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) e Virgie ဥ illiam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, grematory or other place) BATIMOREMD Date 20a. Method of Disposition

1 ☐ Burial 2 CCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State ANSFUNCEACCHAPEC 5-24-64 FOREST HILL MD

22. Name and Address of Facility
2325 YOU'LL RD TIMONIUM MD 21093 21. Signature of Funeral Service Licensee Servetally PEACEPUL ALTERNATIVES I-UNERAL & CREMATION CT at caused tile death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part I. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) unten Examiner EART Due to (or as a consequence of): Physician/Medical Examiner KENAG or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Heart VAKAGUA enic Due to (or as e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Anenia 2 M No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Voluming Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 1 Maturel 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation efter death. I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined To the Hospital or Atte within 24 hours effer del To the Funeral Directo completely filled in by the 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chack only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 0/21/04. 00059056 Medical Doctor 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MT Royal AVE Belt MD 21217 WEST DALJEET SALUJA MD 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAY 2 5 2004 Registrar DHMH 16 Rev 6/95

			Please I		K Indelible Ink. Ensure		
			For	State of Maryland / [	Department of Health and	Mental Hygien	
			1 - State Registrar		Certificate of Death	Reg. No	.2004 16580
			1. Decedent's Name (First, Middle, Last)	- / /	1	2. Date of Death	3. Time of Death
п	Physici	an	Marie (	(rabine	0+	Month Da	ay Year Sound
	/Medi		111011	3.04		11/4/ 2	2, 2004 S.10FM
1	Examir	ier	4a. Facility Name (If not institution, give	A Page Land (Ulliber)	4b. City, Town, or Location of Dea	tn 40	c. County of Death
			1406 Meadon	Branch Cr.	paltimor	e	Baltimore Co.
п	Funeral		5. Social Security Number 6. Sec	I offer	Months Days Hours Min		9. Birthplece (State or Foreign
н	Director		20 (22)	81	Yrs.	140V-11, F	Ida baltimore, MI
	P		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town			
	aryla tho	_	Ma. State	O OC. City, Town	n or Location		10d. Inside City Limits
	W F	cto	Maryland 129 /Tix	nore co. Bali	MORE		1 □ Yes 24 No
	T 28	Director	10e. Street and Number	0 10/1	10f. Zip Code	10g. C	itizen of What Country?
	72 hours after death with the Maryland 'natural', or Items 23a or 28e-f show dical Examinational be notified at	a D	7406 Meadow	Branch Ct.	2/237	10	1 · S. H.
	deat ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
10	r ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		to Rican, etc.)	Black, White, etc.
336	lrs a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 22 No Specify:		Specify: White
5-0036	ture	Completed by	15. Decedent's Edu	cation 16a.	Decedent's Usual Occupation	16b #	Kind of Business/Industry
15	n 7	let	(Specify only highest grade	completed)	(Give kind of work done during most of wo life. DO NOT use retired)	rking	and or business modelly
2121	within ene. than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Lame Maker		Own Home
77	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)		18 Mother's Na	me (First, Middle, Maider	
3D	e d o	Be		rio	Caca	1 100	Singularity 1/0
ž	should be and Mental is marked of aumatic eve	70			Carc	,,,,,,	sarano
Maryland	2 sh and is rr		19a, Informant's Name/Relationship (Ty	/ / / / / /	. Mailing Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code) 21237
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23s or 28e-1 show other traumatic event, if a Mudicul Examination in Indian at		Mr. James J.C	135.40	406 Meadow Bi	anon Cr.	Apric. Balto, P.D.
Baltimore,	ges 1 al 1 of Hea 1f item or othe		20a. Method of Disposition	cometer	Disposition (Name of ry, crematory or other place)		ocation - City or Town, State
Ĕ	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	reland Mem. Park	726, Be	altimore, MX.
Ξ			21. Signature of Funeral Service License		22. Name and Address of Facility	1	ofalt Com to M
B	permit. Departr Imports any inju		rephon it	Jan. Dr	Peaceful Alter	87 Ves oun	elul + Cremanon Ch
			23a. Part I Inter the disease, or compli	chos that arread the death. Do s	12323 900 K	- RI IIMO	nium, MD, 21093 Approximate
		7 1		cause on sch line.	not enter the mode of dying, such as cardia	c or respiratory arrest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	(-12N3	( SNCES		Onsol and Death
V.	/Medical		resulting in death)	Due to (or as a consultence of	of):		
13	Examiner		Sequentially list conditions				
		ē	if any leading to immediate	Dua to (or as a consequence :	u()·		
	uted d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events				
Ć,	be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a consequence of	of):		
09/	e be ex sician e burial	<u>a</u>					
687	death certificate e attending physi d for use as the t	Physician/Medic					
×	ding se a	W.	IF FEMALE:	3c. If yes, outcome of pregnancy	= = = = = = = = = = = = = = = = = = = =		
Box	ath o	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
	0 0	SIC	1 ☐ Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		North Day 10ai
P.O.	that the de led by the a detached	h,	9 □ Unknown				
	The law requires that the to has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
5	w require been sign					1 20 es 2	□ No 3 □ Probably 4 □Unknown
Vital Records,	w requ	Completed				24a. Was an	24b. Were autopsy findings available
Re	has has ge 2	E				autopsy performed?	prior to completion of cause of death?
=						1□ Yes 2 No	
)į	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?		1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	ath Check onl one	
of	di S	2	1 □ Yes 2 No	ospital: 1 Inpatient 2 ER/Out	tpatient 3 DOA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specify)
	ding Ph h. After th tuneral	ü	27. Manner of Ceath  1 Natural 5 □ Pending	28a. Date of Injury 28b. T (Month, Day Year) Ir	ime of 28c. Injury at work?	28d. Describe how inju	ry occurred
<u>ō</u>	ttendir death. ctor: Af / the fu	atlo	2 Accident investigation	(,,,	M 1 ☐ Yes 2 ☐ No		
Division	Il or Attending after death. Director: After d in by the fune	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, far	rm, street, factory, office	28f. Location (Street ar	nd Number or Rural Route Number,
ā	afte Dir	Certification:	4 🗆 Homicide	building, etc. (Specify)		City or Town, State	9)
	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certifying Phys	icien: To the best of exy knowledge	, death occurred at the time, date and place	and due to the cause/s	) and manner as stated
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medicel Exemir	er: On the basis of examination and	dor investigation, in my opinion, death occu	irred at the time, date and	d place, and due to the cause(s)
	thin the	Me	29b. Signature and title of certifier	and marries states.	29c. License number	29d Da	ite signed (Month, Day, Year)
	0				250. Elonio Hambo	250. Da	orgina prioriti, Day, real)
	- 3 - 0/			1 / 4	11/10001	474	104124
2	1		16070	- 1 leno	1000	2/( ) /	12110
2	h		30. Mame and address of person who co	mpleted cause of death (Item 23a) (	Type, Print)	= 0 /	7
2	1		Ve- George	mpleted cause of death (Item 23a) (	Type, Print 9512 He	Forla	2
2	1		30. Mame and address of person who co 31 Date filed (Month, Day, Year) MAY 2 5 2004	mpleted cause of death (Item 23a) (	Type, Print) 9512 Hz	For & Re	2

Physici /Medic	an_	Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	No. 2004 1651 Day Year 3. Time of Dea
risical		Peggy Lou German		May 17.	2004 6:40P
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	c. County of Death
Francis		Greater Baltimore Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last bit	Towson  rthday) If Under 1 Year   If Under 24 Hrs.	9 Date of Birth	Baltimore
Funeral Director		577-32-5075 1 M 2 X F 83 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug. 5, 19	9. Birthplace (State or For Country) Pennsylvania
if any 2 should be incommined with the marking of health will the marking of health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinat must be notified at	20	10a. State 10b. County 10c. City, Tow Maryland Baltimore Tows			10d. Inside City Lir 1 ☐ Yes 25
28a-f	rect	Maryland Baltimore Tows	10f. Zip Code	100.0	Citizen of What Country?
23a or	I DI	800 Southerly Ave. Apt.905	21286	USA	·
SILING SELOW	by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
tural', or items 23	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No — If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Hican, etc.)	Black, White, etc.
"natural",	d þ	3 XWidowed 4 Divorced Year or Dates:			Specify: White
"nat	Completed	(Specify only highest grade completed)	<ul> <li>Decedent's Usual Occupation         (Give kind of work done during most of working life. DO NOT use retired)     </li> </ul>	ng 16b.	Kind of Business/Industry
h and Montal Hygiene. 7 Is marked other than ". Ireumatic event, he Med	omp	Elementary/Secondary (0-12) College (1-4or 5+)	Home Maker		Own Home
othe	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	
Menta rked tic ev	To B	Edwin H. Allison	Myrtle	Rish	eberger
and I		19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or Rura		
ealth m 27 ner tr		Karen A. Heier / Daughter 19	931 Fallston Valley D:	rive Falst	on,Md. 21047
H ite		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	f Disposition (Name of ry, crematory or other place)	ate 20c. I	Location - City or Town, State
tmen tent: jury		`4 □Donation 5 □Other (Specify) Hillt	op Service Corp.5/20/	Ό4 Τοι	wson, Maryland
Department of Health a importent: If item 27 is eny injury or other tree		21. Signature of Fundral Bervice Liouvie	22. Name and Address of Facility		1050 York Road
	-	23a. Part, enter the disease, or complications that caused the death. Do not be the complete the	Ruck Towson Funeral	Home, Inc	Towson, Md.21204
sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the cause) Due to (or as a consequence of the cause).			
	cal	d 3	)		
2 %					
e attending phy of for use as the	ysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown 9	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ed by the attending phy detached for use as the	y Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Ulrknown	5 Other (specify)	23e. Did tobacco	Month Day Year
e attending phy of for use as the	by	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 9 ☐ Unknown	5 Other (specify)	23e. Did tobacco	Month Day Year use contribute to the cause of death?
e attending phy of for use as the	by	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Ulrknown	5 Other (specify)	1 ☐ Yes 2	Month Day Year  use contribute to the cause of death? □ No 3 □ Probably 4 □Unkno
has been signed by the attending phy e.2 should be detached for use as the	ompleted by	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Ulrknown	5 Other (specify)	1 ☐ Yes 2  24a. Was an autopsy performed?	Month Day Year  use contribute to the cause of death?  ! No 3 Probably 4 Unknot  24b. Were autopsy findings availa prior to completion of cause death?
ificate has been signed by the attending phy for, page 2 should be detached for use as the	e Completed by	23b. Was decedent pregnant in the past 12 months?  1    Yes    25 No	5 □ Other <i>(specify)</i> The underlying cause given in Part I.	1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No	Month Day Year  use contribute to the cause of death?  ! No 3 Probably 4 Unknot  24b. Were autopsy findings availar prior to completion of cause death?
is certificate has been signed by the attending phy director, page 2 should be detached for use as the	o Be Completed by	23b. Was decedent pregnant in the past 12 months? 1   Yes   25   No	5 ☐ Other (specify)  The underlying cause given in Part I.  26. Place of Death	24a. Was an autopsy performed?  1 Yes 2 No. (Check only one)	Month Day Year  use contribute to the cause of death?  No 3 Probably 4 Unknot  24b. Were autopsy findings availa prior to completion of cause death?  1 Yes 2 No
fler this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions   Unknown   Unknown    25. Was case referred to medical examiner? 1   Yes   2   No   Variety   V	The underlying cause given in Part I.  26. Place of Death  Other: 4 \( \text{Nursing Hom} \)  Value of 28c. Injury at 2	1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No	Month Day Year  use contribute to the cause of death?  No 3 Probably 4 Unknot  24b. Were autopsy findings availa prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)
fler this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions antribution to death at not resulting in the past 12 months?  25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death   1   28a. Date of Injury   28b. The past of the pa	5 ☐ Other (specify)  The underlying cause given in Part I.  26. Place of Death  Ipatient 3 ☐ DOA	24a. Was an autopsy performed?  1 Yes 2 No.  (Check only one)  1 Se 5 Residence	Month Day Year  use contribute to the cause of death?  No 3 Probably 4 Unknot  24b. Were autopsy findings availa prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)
death. ctor: After this certificate has been signed by the attending phy y the funeral director, page 2 should be detached for use as the	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions   Unknown  Part III. Other significant conditions   Unknown   Unk	The underlying cause given in Part I.  26. Place of Death  Other: 4 \( \text{Nursing Hom} \)  Norther: 4 \( \text{Nursing Hom} \)  1 \( \text{Yes} \)  1 \( \text{Yes} \)  2 \( \text{Norther} \)	24a. Was an autopsy performed? 1	Month Day Year  use contribute to the cause of death?  24b. Were autopsy findings availa prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  In occurred
death.  ctor. After this certificate has been signed by the attending phy y the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	26. Place of Death    Deatient 3   DOA   Other: 4   Nursing Hom	24a. Was an autopsy performed? 1	Month Day Year  use contribute to the cause of death?  24b. Were autopsy findings availa prior to completion of cause death?  1 Yes 2 No  6 Other (Specify)  In occurred
death.  ctor. After this certificate has been signed by the attending phy y the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant conditions untribution to death it not resulting in a saminer?  1   Yes   2   No   Hospital:   Impatient   2   ER/Out    27. Manner of Death   Impatient   2   ER/Out    28a. Date of Injury   28b. T   Conding   Investigation   28c. Place of Injury - At home, far building, etc. (Specify)	The underlying cause given in Part I.  26. Place of Death  27. Place of Death  28c. Injury at  Work?  1 Yes 250 No  The street, factory, office	24a. Was an autopsy performed?  1	Month Day Year  use contribute to the cause of death?  I No 3 Probably 4 Unkno  24b. Were autopsy findings availa prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify) In occurred
death.  ctor: After this certificate has been signed by the attending phy y the funeral director, page 2 should be detached for use as the	ledical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions untribution to death to resulting in the past 12 months? 1   Yes   2   No   No   No   No   No   No   No	The underlying cause given in Part I.  26. Place of Death  27. Place of Death  Other: 4 Nursing Hom  Work?  1 Yes 25 No  Tm, street, factory, office  death occurred at the time, date and place, are for investigation, in my opinion, death occurred.	24a. Was an autopsy performed?  1	Month Day Year  use contribute to the cause of death?  I No 3 Probably 4 Unknow  24b. Were autopsy findings availal prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  In occurred  and Number or Rural Route Number, e)  A L Y A L TOWSE  and manner as stated a see(\$1.22)  and manner as stated a see(\$1.22)
in 24 hours after death.  The Funerel Director: After this certificate has been signed by the attending phy pletely filled in by the funeral director, page 2 should be detached for use as the	ledical Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  Part II. Other significant conditions untribution to death to resulting in the past 12 months? 1   Yes   2   No   No   No   No   No   No   No	26. Place of Death  27. Place of Death  28. Injury at Work?  1 Yes 2 No  The street, factory, office  28. death occurred at the time, date and place, are for investigation, in my opinion, death occurred.	24a. Was an autopsy performed?  1	Month Day Year  use contribute to the cause of death?  I No 3 Probably 4 Unknow  24b. Were autopsy findings availal prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  In occurred  and Number or Rural Route Number, e)  A L Y A L TOWSE  and manner as stated a see(\$1.22)  and manner as stated a see(\$1.22)

WENDED BY COURT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend statem of Mary land / Separtmender Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year NAVIS **PEARL** GRINNAM 19, MAY 2004 3:36 PMM /Medical 4a. Facility Name (If not institution, give street and number)
JOSEPH RITCHIE HOSPICE HOUSE
828 NORTH EUTAW STREET 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F 78 Yrs Director 2/9/1926 **HONDURAS** Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 17 Is marked other then "naturel", or Items 23a or 28a-f show traumetic event, the Medical Examination institute the modified at 10d. Inside City Limits 1√XYes 2 No MARYLAND PRINCE GEORGES **SEABROOK** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #102 9949 GOOD LUCK ROAD 20706 death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Ia marked other then "naturel", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 VYes 2 □ No Specify: þ Specify: BLACK HONDURIAN 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 REGISTERED NURSE NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FREDERICK MARTINEZ ETHEL PARKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i 1 and 2 st of Health ar fitem 27 le 9949 GOOD LUCK ROAD, #102, SEABROOK, MARYLAND 20706 CLARISSA COLEMAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 X Kurial 2 Cremation 3XX Removal from State 5/28/2004 ' 4 Donation 5 Other (Specify) CORAL RIDGE CEMETERY CAPE CORAL, FLORIDA 21. Signal In J Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY PRECORY FINK 426 CRAIN HICHWAY S., GLEN BURNIE, MARYLAND 21061 #M01148 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or co dition resulting in death) Physician failure Renal 1 neverth /Medical Due to (or as a consequence of): Examiner 5 Years Arturoschuotz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Jrinnam IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of the Alcherm type, seril Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 14 07 Pice Hospital: 1 ☐ Yes 2 Z No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D completely filled it Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Dollar Jim DO62175 5-19-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROTH B. FIMN, 8824 Winards Road, Randellstown. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 10 /Medical 4a. Facility Name (If not institution, give street and number) Examiner Ab. City, Town, or Location of Death 4c. County of Death Baltimore C 4/2 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** -34-72 Director NORTH CAROLINA Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Itema 23e or 28a-f show 28a-f show 1 Yes 2 □ No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 N. HIGHLAND AVE. 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: WW II Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>م</u> 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 STEEL WORKER BETH STEEL marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I JAMES WEAVER GLASS SYLVANIA SMITHEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is n any injury or other traun 9 MRS. LYDIA GLASS / 111 N. HIGHLAND AVE. BALTIMORE, MD. 21224 WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State ¹ 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILL MEM.GRDS. 5/26/04 MIDDLE RIVER, 21. Signature of Funeral Service KÄCZÖRÖWSKI FEUNERAL HOME P.A. Car 1201 DUNDALK AVE. BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Reval Cell Carcinoma Metacratic Physician 1 + ocontas resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physiclan/Medical as the IF FEMALE: esn 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð End Ltare Penal Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕦 Onknown Completed Deen Cornay Artery Discase 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ②No 24a Wasan has page erebrounden Accident certificate 1 Yes 2 2No Division of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Senursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 3 DOA this After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation To the Hosping.
within 24 hours after death.
To the Funaral Director: Afr 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number wwww D19667 05-23-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BMO 21224 und 1360 5. Donier SWANT ZMIN Burrows 31. Date filed (Month, Day, Year) MAY 2 5 2004 32. Registrar's Signature State Registrar

PHNH 17 Rev 1/2001

	1	For State Registrar			-	tment of F			Reg. No.	2004	1658
Physician /Medical		Decedent's Name (First, Middle, L. CPTHERINE  a. Facility Name (If not institution, gi	9	DO		Ab City Town o	r Location of Deat	2. Date of De Month	Day	Year 200/ County of Dea	
Examiner Funeral Firector	5	Chapel Hill i. Social Security Number 6.	Nursno	g G e) in yrs. Ia	R ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	wnML	th ly, Year)	9. Bi	thplace (State or Forei Jountry) Pennsylvan
iffied at		Maryland Baltimo	re		Town or Loca lallsto						10d. Inside City Limit
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Eranirer must Eranirer must by Funeral	5	1. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 1 1 If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)		Black, Whi	erican Indian, ite, etc. Vhite
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ed other the event, the	1	6th  17. Father's Name (First, Middle, Las Paul Penkala	st)		Homema	ker	18. Mother's Nar	ne <i>(First, Middle,</i> .ne Rac]			
4 4 5	1	19a. Informant's Name/Relationship Geraldine Clemer		ghter		Address (Street a	and Number or Re Road, Ra	ral Route Numbe	er, City or	Town, State, MD 211	Zip Code)
Department of nearth Importent: If item 27 any injury or other tr	2	20a. Method of Disposition  1   XBurial 2 □ Cremation 3    4 □ Donation 5 □ Other (Spec		cei	ly Trin	itory or other place ity Ceme	etery May		04 Ya		. Pennsylva
Import any inj	2	21. Signature of Funeral Service Lice	ensee		22	Name and Address	on of Continu	ing Bye	rs Fu	meral	Directors,
-		1000		033	3 872	8 Libert	y Rd. Re	mdallst	own,	MD 211	
burial-transit burial-transit al Examiner		23a. 19/1. Enter the Tisease, or cor ock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, recurring to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		the death.  STV a conseque	872 Do not enter EHE ence of): OUTC	8 Libert the mode of dyin	y Rd. Re	mdallst	own,	MD 211	Approximate Interval Between Onset and Death
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State Registrar DHMH 17 Rev 1/2001

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DL		Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	No. 200	3. Time of Death
Physici Medic/		EDITH	GOLD	MAY 20	0 2004 ear	11:30 A
xamin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
eral		JEWISH CONVALESCENT & NURSING HOME 5-Speial Security Alumber 6. Sex 7. Age (In yrs. last birthe	PIKESVILLE ay) If Under 1 Year   If Under 24 Hrs.		BALTIMORE	
ar or		5 Spelal Recyclin demoer  1 M 2 F F 82 Yr	Months Days Hours Min	8. Date of Birth Month, 25, 1	.922 <sup>9. 8</sup>	thplace (State or Foreig ountry) MD
		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			
	ğ	,	IDALLSTOWN			10d. Inside City Limit 1 ☐ Yes 2 ☐ N
	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	
	alD	3710 TRENT ROAD	21133			U.S.A.
	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F</li> </ol>	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whi	
	byF	1 ☐ Never Married 2 【M Married 1 ☐ Yes 2 【M No If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:		Specify:	WHITE
	ted	15. Decedent's Education 16a. D	cedent's Usual Occupation	16b	. Kind of Business	
	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of working.  DO NOT use retired)	g		•
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	으		TILLER ROSE ailing Address (Street and Number or Rural	Route Number, Cit	tv or Town State	COOPER
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		20a. Method of Disposition  1 🔏 Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition	sposition (Name of Da Prematory or other place)	ite 20c.	. Location - City or	Town, State
		`4 ☐Donation 5 ☐Other (Specify) HEBREW	YOUNG MENS CEM 5/21,		WOODLAWN	
ouce		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL 8900 REISTERSTOWN RO			
j		23a. Part1. Enter the disease, or comblications that caused the death. Do not shock, or heart failure. List only one cause on each line.		respiratory arrest,		Approximate Interval Between
١		resulting in dealth)	clerosus			20 Year
ı		Due to (or as a consequence of):				·
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury				,
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	cal Ex	Due to (or as a consequence of):				
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l	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ven/
	Physician/Med	in the past 12 morths?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	B DEctopic pregnancy Description of the control of		Month	Day Year
	by Phy	Part II. Other significant conditions contributing to death but not resulting in th	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
	ed b	Alzheiner's Visease		1 🗆 Yes	2.2 No 3 □ Pr	obably 4 Unknown
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	Com			autopsy performed?	death?	completion of cause of
	Be	25. Was case referred to medical examiner?	26. Place of Death (			
	2	1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpat 27. Manna of Death   28a. Date of Injury   28b. Time		5 Residence		city)
	tlon	27. Manne of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injury Injury		d. Describe how in	jury occurred	
l	itica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm,		f. Location (Street	and Number or Ru	ral Route Number,
	Certification;	4 Homicide building, etc. (Specify)		City or Town, Sta	110)	
	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	Ž	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month	, Day, Year)
		1 Crown	D0020964	May	20, 200	4
		30. Name and address of person who completed cause of death (Item 23a) (Typ	e. Print)			
tai			berty Plaza Mall Ra	ndallsto	wn, MD 2	21133

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Cecilia Hudgins 2004 7:50p. Aurelia May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Future Care Nuring Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months Days Hours 1 M 2 1 F 20 98 MD Director 217-22-0730 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23e or 28a-1 show any injury or other traumatic event, the Mudical Example at most Le modified. 2006. 1 Yes 2 No Director MD Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21207 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2X No If Yes. Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify. If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City House Keeping 2th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Cook ဂ္ Harry Johnson 21201 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constantina-DeShields 124 West Franklin Street, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition NBurial 2 Cremation 3 Removal from State 4 Opnation 5 Other (Specify) Arbutus Memorial Park 5/28/04 Arbutus, Md 21. Signa ure of Funeral Service Licensey 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Demento Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disease The law requires that the death certificate be executed Due to (or as a of sequence of): and Division of Vital Records, P.O. Box 68760 the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Junknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 🕒 NO Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. ENTAW St Fente 304 of Honi 821 mp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 2 5 2004 Dacks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 05 12:35 M 2004 /Medical 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritan Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.

Months Days Hours Min. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 F Director 210-110-5102 Usual Residence of Decedent Mak 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ita Medicul Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD BALTIMORES PARKVIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2511 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 home maker none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jarius lorence 19a. Informant's Na lelationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) harles Harkville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State \* 4 Donation 5 Dother (Specify) Dulaney Valley Men Gar. 5-25-04 Timonium n 22. Name and Address of Facility BALTIMORE MO 21234 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. EVANS FUNERAL CHAPEL, 8800 HARFORD RD to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner iver Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of o the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit MONON Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed? Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) N. Mejevoi, 05/21/04 KE SOOO

State Registrar

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31. Date filed (Month, Oay, Year) MAY 2 5 2004

32. Registrar's Siggature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. Mejevoi, 5601 Loch Rowen Blvd., Baltimore, MD 21239

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į.			Registrar     Decedent's Name (First, Middle, Last)			001	incate	J UI L	Jean	-	2. Date of	Reg. N Death	lo.	6,5 J	3. Time of	Death
	Physicia		Paulene Hahn								Month	24		Year 204	1:00	
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, 7	Town, or	Location of	of Death	,		c. County			
	CAGIIII	-	Northwest Hospit	al conter			Rand	alls	town				Balt	imor	-	
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	the t	Director	10e. Street and Number	IOLC		OWL	10f. Zip		,			10g. C	Citizen of W	/hat Cour	itry?	
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Baltimore,	it. Pertrant		21. Signature of Funeral Service III Service		Metro	Cre	mator	y, ]	nc .	5/25	5/04		Ealti	more	, MD	
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical (	29a. Certifier (Check only one) The Certifying Physical Examination (Check only one)	ician: To the best of ner: On the basis of e and manner state	examination an	e, death	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to to d at the tim	he cause( ie, date a	s) and mar nd place, a	nner as st nd due to	ated. the cause(s)	
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	6		30. Name and address of person who co S401 Old Court 12	mpleted cause of dea	ath (Item 23a)	(Type,	Print) N 1, Mai	ylo	ind	Meji	a, N					
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ĺ	Funeral	iei	124 Jefferson Aver 5. Social Security Number 6. Se	iue x 7. Age	a (In yrs. last birthday)	Cockeysv	rille If Under 24 Hrs.	8. Date of Birth	Baltimore	nplace (State or Foreign
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Maryland	should be and Mental s marked c	To Be	Edward Heayn  19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street	<u> </u>	Ellen Goo	dchild City or Town, State, Z	ip Code)
Baltimore, M	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other trei ODCB.		Margaret Heayn  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of June 18 Service Lipens	Removal from State	20b. Place of Disposementary, cran	sition (Name of natory or other pla Prvice Co . Name and Addre	orp. 5/24	Date 2	ille, MD 2 oc. Location - City or 1 owson, MD 1050 Yorl Towson, 1	own, State
8760,	bhysician with Examiner and prize be executed whysician and prize transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	the death. Do not entered a consequence of):	er the mode of dyir	ng, such as cardiac			Approximate Interval Between Onset and Death STOURS  Years
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Division of Vita	Attending Physicien: Th r death. ector: Alter this certificate by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner?  1	1 Inpatier 28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injur Wor M 1 [	ner: 4 Nursing H	28d. Pescribe how	ice 6 Other (Speci	
Divi	spitel or Attend ours after death nerel Director: / filled in by the f		4 Homicide determined	building, etc.	ry - At home, farm, stre . (Specify) f my knowledge, death		me date and place	City or Town,		
<b>,</b>	To the Hospitel or Atte within 24 hours after de To the Funerel Directe completely filled in by the	Medical	(Check only 2 Medical Examinate)  29b. Signature and title of certifier	ner: On the basis of and manner stat	examination and/or inv	estigation, in my o	pinion, death occur se number	red at the time, dat	e and place, and due t  d. Date signed (Month,	o the cause(s)  Day, Year)
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Physic /Medi		FERNANDIS	BOWEN	HOERL,	JR			MAY	33	200	4 1:03 AM
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Funeral Director		5. Social Security Number 6. Sex	1	e (In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Yeer)	9. Bi	rthplece (State or Foreign ountry)
D		Usual Residence of Decedent		10c. City, Town			l		-		
Manylar f ehov	5	MARYLAND ANNE A	RUNDEL			N BURNIE					10d. Inside City Limits 1 ☐ Yes 2 XNo
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ath wit		301 RAINWATER WAY, AF			140.1		21060			sa	in a testion
ETZIS-UU3D  within 72 hours after death with the Maryland jiene. rthen "naturel", or Items 23s or 28s-1 show the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 WWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2(X)! If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXNo	ispanic Origin? (S in, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)		14. Race - Am Black, Wh Specify:	
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should be nd Mental marked o	To B	FERNANDIS BOWEN HOE						ICY SAYLES			
re, Maryis s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty				ng Address <i>(Street a</i> LLOW COURT,				Town, State,	Zip Code)
Baltimore, Maryland 2: servilled variet. Peges 1 and 2 should be filed value from the filed value from the filed value from the file from 27 is marked other two myoriqury or other traumatic event. In page.		CORINNE HENDRICKSON - 20a. Method of Disposition		20b. Place of	Dispo	esition (Name of matory or other place		Date Page		cation - City o	Town, State
Peges ment of a		1 ☐ Burial 2 ☐ Sremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			REMÁTORY		/2004	Balt	imore, N	1D
baltimo permit. Peg Department Important: II any injury o		21. Signature of Funeral Service Ligens	· Land			2. Name and Addres					
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or				er the mode of dyin				21061	Approximate
Physician		Immediate Cause (Final disease or condition resulting in death)	00.	no. 15tatic		Rectal	CANC				Interval Between Onset and Death
/Medical Examiner			Due to (or as	a consequence o	of):						
P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	& consequence o	of):						
60, be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last		a consequence of	of):						
/6U e be e /sician e buria	<u>6</u>		,								
c 68/ ortificate ing phys	Medi	IF FFMALF:						-			
J.O. BOX 68/6U, at the death certificate be ex by the attending physician tached for use as the buria	Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			2	3d. Date of de Month	olivery Day Year
<b>*</b> 2 8 8	by Ph	Part II. Other significent conditions con	ntributing to death b	ut not resulting in	the u	nderlying cause give	en in Part I.	23e. Did t	obacco us	se contribute t	o the cause of death?
COLDS w require been sig								1 🗆	Yes 2	24¶0 3 □ P	robably 4 Unknown
The la	Completed							24a. Was auto perfo 1 Yes	osy rmed?	prior to death?	utopsy findings available completion of cause of s 2 No
	o Be	25. Was case referred to medical examiner?	lospital:	2 DEB/O		nt 3 DOA Othe	20	ath (Check only o			
g Physical chils	11	27. Manner of Death	28a. Date of Inju (Month, Da		ime of njury	IL 3 LOOK	4 🗆 Nursing i	dome 5 Resi 28d. Describe			ecity)
Vision (	catio	1 Adatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 □ No				
DIVISION pitel or Attending ours after death. erel Director: Alte	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At home, fai c. (Specify)	rm, str	eet, factory, office		28f. Location ( City or To		1 Number or F	lural Route Number,
DIV To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	edical	29a. Certifier 1 Certifying Physical Check only 2 Medicel Examione)	sician: To the best ner: On the basis of and manner sta	f examination and	, death d/or in	h occurred at the tim vestigation, in my of	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) a date and	and manner a place, and du	s stated. e to the cause(s)
Tot Tot	Σ	29b. Signature and title of certifier  Hen Z. Fre	mei My	)		DO2	7415			signed (Mon	
4		30. Name and address of person who co					Lundel	Hospi	hal		
St	ate	31. Dam Year	2 32. Registr	ar's Signature			-~11661	1,53171	, , ,		<del> </del>
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			For	State of M	laryland					and M			2001	. 1.	101
			Registrar  1. Decedent's Name (First, Middle, La	etl .		Cei	rtificate	e of L	Jeath	T	2. Date of Dea	leg. No.C	2001	3 Tin	ne of Death
	Physici	an	00	51/	11=						Month YUAY	Day	2 Year		A M
	/Medic Examin		11 a Cq a CC t 4a. Facility Name (If not institution, give	re street and number		alex	4b. City.	Jown, or	Location o	of Death	TUFFY	4c. 0	County of Dea		/3 //
	Exami		The Johns	40 Pkins	5 Has	PilAl	6	1/2	/ .	KE					
	Funeral		5. Social Security Number 6. S		ge (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birtl (Month, Day	( Year)	9. Bi	thplace (St.	ate or Foreign
	Director		050 20 0.00	1 M 2 XX	77	Yrs.	MOULUS	Days	Hours	IVIII I.	1/31/19	27		YORK	
	pud *		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	ocation							10d Insid	le City Limits
	/anyle	ō	PENNSYLVANIA ADAMS	:		W OXFOR									Yes 2 □ No
	28e-	rect	10e. Street and Number		144	OXI OI	10f. Zip	Code				10g. Citiz	en of What C	ountry?	
	172 hours after death with the Maryland "neturel", or Items 23a or 28e-1 show adical Externish be nutitied at	Funeral Director	15 KIMBERLY ANN LANE						1735	0		U	J.S.A.		
	deatl	ner	11. Marital Status	12. Was Deceden Armed Forces		S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		4. Race - Am Black, Wh		n,
9	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🗶			1 Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,	110411, 010.7			HITE	
21215-0036	uret',	d by	3 Widowed 4 Divorced	Year or Dates:	:										
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12	within iene. than "	mo	Elementary/Secondary (0-12)	Coltege (1-4or	5+)		USEWIF						OWN HO	MF	
p	Hyg Hyg Sthe ent,	Be C	17. Father's Name (First, Middle, Las.	)		110	UJLWII		18. Mothe	r's Name	(First, Middle,	Maiden S		11.	
lan	2 should be filed and Mental Hygi is marked other sumatic event,	To B	PATRICK HYNES						М	ARY S	HINE				
Maryland	2 8 8		19a. Informant's Name/Relationship	Type, Print)		1	1	•			Route Numbe			Zip Code)	
	1 and Health Health sem 27		JAMES T. HEALEY		aor Di				LN.,		KFORD, PA				
altimore,	0 0		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3X	Removal from State	1 00	ace of Dispo emetery, crei	matory or o	ne or ther place	9)	D	ate	20c. Loc	ation - City o	r Town, Stat	Θ
ţim			'4 □Donation 5 □ Other (Special		CA	LVERTON				5/21/2			ERTON, 1	YY	
Bal	Departi Departi Importi any inj		21. Signal fe P neral Service Live	1:1	146						FUNERAL EN BURNI				
	Fnysician /Medical Examiner	er	23a. Part I Enter the disease, ot consolors shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. V  Due to (or a)	consequ	Res.s					Seo			Approx Interval Onset	Between and Death
68760,	death certificate be executed e attending physician and ad for use as the burial-transit	edicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a:	s a consequ	ence of):									
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S, D	The law requires that the te has been signed by the bage 2 should be detache	by Pl	Part II. Other significant conditions	contributing to death	but not resu	ilting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute t	o the cause	of death?
rds	v require been sig should b		Aute Respira.	by 0.	5+105	5_5	Synd	1000	e		1 🗆 Y	es 2 <table-cell></table-cell>	No 3 □ P	robably 4	Unknown
Records,	e law re has be le 2 sho	Completed	Acute Rena	Fai	lure	,					24a. Was a autop	5Y	24b. Were a prior to	utopsy findi	ngs available of cause of
<u>=</u>		Cou									perfor	med? 2 ☑ No	death?	2 🗆 No	
Vital	ıysiclen: Th iis certificate director, paç	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only or	ie)			
of	Phys this al dii	J.	1 ☐ Yes 2 ☑ No  27. Manger of Death	1 Inpat		ER/Outpatier			4 🗆 140		ne 5 Resid			ecify)	
ion	ling After une	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D.	ay Year)	28b. Time of Injury	M	8c. Injury Work 1 🔲 Y	at ? ′es 2 □ 1		8d. Describe h	ow injury	occurred		
Division	To the Hospitet or Attend within 24 hours after death To the Funerel Director: , completely filled in by the 1	Certification:	3 Suicide 6 Could not to determined	209. Flace 01 II	njury - At ho etc. (Specify	me, farm, str	reet, factory	, office		2	8f. Location (S City or Tow	treet and n, State)	Number or R	ural Route	Vumber,
	To the Hospitet or A within 24 hours after To the Funerel Direct completely filled in by	edicai	29a. Certifier 1 Certifying P (Check only one) 2 Medicel Exe	nysicien: To the bes miner: On the basis and manner s	of examinat	wiedge, deatl ion and/or in	h occurred vestigation,	at the tim in my op	e, date and inion, deal	d place, a th occurre	nd due to the c id at the time, d	ause(s) a ate and p	and manner a place, and du	s stated. e to the cau	se(s)
	Fo the vithin Fo the complex	Me	29b. Signature and title of certifier				29c	. License	number		2	9d. Date	signed (Mon	th, Day, Yea	ar)
			Canal SR	a	20		R	65	-000	)		101	15	2001	/
	6		30. Name and address of person who	completed cause of	death (Item	23а) (Туре,			UUU		1/1	1614		x00.9	
			Courtney Bellows	mo 600	North	water	Sice	et, n	Darbu	119 B	186 B	alt in	ac 1	10 0	287
	Sta		31 MAY 2 (M5 th 2004 ear)	O2. Hegist	trar Signat	ure 400	do			1			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May **Physician** 2:31 PM FRANKLIN PAGE HAINES 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Haspital George's Regional Laurel Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 2, 193 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1√2M 2□F Yrs. West Virginia 218-34-5355 65 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event. In Medical Examinating profiting at once. 10d, Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 16207 Jerald Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Yes Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Distributor Wholesale Meat 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Guy Russell Haines Gladys Irene Kagey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Haines / daughter 16207 Jerald Road Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Dopation 5 ☐ Other (Specify) West Arundel Crem. 5/28/2004 Odenton, Maryland 21. Signature of Funeral Service Licenses 2Domandswis fumeral Home, P.A. M00773 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the press, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear in ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSION ULMOHARY 2 NEARON **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FIBROSIS ILMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner OBSTRUCTIVE LUNG DZ The law requires that the death certificate be executed use as the burial-transit HRONIC and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown Month Year in the past 12 months? Day 5 Other (specify) Yes 2 No 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. eq 1 ☐ Yes 2 ☐ No 3 Probebly 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has page 2 autopsy parformed? Yes 21. No this certificate 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ▼ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43575

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

AYREL

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350

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32 Registrar's Sanature

			For State		partment of Health and Me <i>rtificate of Death</i>		2001 15500
			1. Decedent's Name (First, Middle, Las		Stillicate of Death	Reg. i	3. Time of Death
	Physici	an	LUCAS	HARRIS			18 2004 2:43PM
	/Media		4a. Facility Name (If not institution, give		4b_City, Town, or Location of Death	11/49	4c. County of Death
	Examir	ier	Sinai Hos	Dital	Baltimore MI		N/A
			5. Social Security Number 6. S	x 7. Age (In yrs. last birthda	10	8. Date of Birth	9 Birtholace (State or Foreign
	Funeral Director		1	M 2□F 74 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Country)
			233-42-5535 Usual Residence of Decedent			11/06/1	929 MD
	ylanc		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Man	ţō	MD N/A	BALT	IMORE		1 XYes 2 □ No
	r 288	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	3a o	0	3130 VIRGINIA	AVENUE	21215		USA
	death	Funerai	11. Marital Status		B. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
(0	if the	F	1√Never Married 2 Marned	Armed Forces? 1,∏Yes 2 □ No ff Yes, Give		Rican, etc.)	Black, White, etc.
ဗ္ဗ	urs a	b	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates:	1 ☐ Yes 2 🎇 No Specify:		Specify: BLACK
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ed other then "netural", or items 23a or 28a-f ehow event, I'm Medical Examiner must be noullied at	Completed by	15. Decedent's Ed		cedent's Usual Occupation	16b.	Kind of Business/Industry
돐	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ve kind of work done during most of worki . DO NOT use retired)	-	ELF
7	d wit	ПО	11TH		NSTRUCTION		MPLOYED
	be file la! Hy d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	
<u>a</u>	should be nd Menta marked imatic ev	ToE	UNKNOWN		UNKNOW	N	
Maryland	" =		19a. Informant's Name/Relationship (7	Type, Print) 19b. Ma	iling Address (Street and Number or Rura	al Route Number, City	y or Town, State, Zip Code)
	end 2 salth a n 27 is		MATTIE JACKSON	FRIEND 313	30 VIRGINIA AVE,	BALTIMO	RE. MD 21215
Baltimore,	f Heart f Heart from othe		20a. Method of Disposition	20b. Place of Dis			Location - City or Town, State
9	Pages nent of int: If it		1 Burial 2 Cremation 3 \( \) 4 Donation 5 Other (Specify	Removal from State METRO		/2004 BA	LTO. MD
₹	nit. Partme		21. Signature of Funeral Service Licen			-	
Ba	permit. Depart Import eny inj once.		11/14	X X 17.	HO		ERAL HOME
			23a. Parts Enter the disease, or comp	1. 1 Cours	600 LIBERTY HGH	TS AV, B	
				plications that caused the seath. Do not e one cause on each line	inter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and De Th
	Physician		Imm diate ause (Final disea e condition result in in death)	· (arcinoma	of luna		= man/h
13	/Medical Examiner	9	resulting in death)	Due to (or as a consequence of):	717		
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	₽ ≒	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	Additional of the same Water and the same of		
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ເດ	0 5	Examiner	Cause (Disease or injury	cDue to (or as a consequence of):			
$\Xi$	ite be executed lysicien and ne burial-transit	cal	Cause (Disease or injury that initiated events	c. Due to (or as a consequence of):			
89		cal	Cause (Disease or injury that infiated events resulting in death) Last	cDue to (or as a consequence of):			
89		cal	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d			23d. Date of delivery
89		cal	Cause (Disease or injury that infiated events resulting in death) Last	d	E⊏ctopic pregnancy		23d. Date of delivery Month Day Year
89		cal	Cause (Disease or injury that infitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d			-
P.O. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{ Yes} \) 2 \( \text{ No} \) 9 \( \text{ Unknown} \)	d	Other (specify)	23e. Did tobacco	-
P.O. Box 68		by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{ Yes} \) 2 \( \text{ No} \) 9 \( \text{ Unknown} \)	d	Other (specify)	23e. Did tobacco	Month Day Year  o use contribute to the cause of death?
P.O. Box 68		by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{ Yes} \) 2 \( \text{ No} \) 9 \( \text{ Unknown} \)	d	Other (specify)	1 Tes	Month Day Year  o use contribute to the cause of death?  2 \[ No 3 \[ \] Probably 4 \[ \] Uwknown
P.O. Box 68	iaw requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{ Yes} \) 2 \( \text{ No} \) 9 \( \text{ Unknown} \)	d	Other (specify)	1 Yes  24a. Was an autopsy performed2	Month Day Year  Do use contribute to the cause of death?  2 No 3 Probably 4 Durnown  24b. Were autopsy findings available prior to completion of cause of death?
P.O. Box 68	iaw requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	□ Other (specify)underlying cause given in Part I.	1 Yes  24a. Was an autopsy performed? 1 Yes 2	Month Day Year  Do use contribute to the cause of death?  2 No 3 Probably 4 Durnown  24b. Were autopsy findings available prior to completion of cause of death?
P.O. Box 68	iaw requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	underlying cause given in Part I.	1 Yes  24a. Was an autopsy performed? 1 Yes 2 (Check only one)	Month Day Year  Do use contribute to the cause of death?  2 \[ \text{No} \] 3 \[ \text{Probably} \] 4 \[ \text{Duwnown} \]  24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \text{Yes} \] 2 \[ \text{No} \]
P.O. Box 68	iaw requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	To Be Completed by Physician/Medical	Cause (Disease or injury that infitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	underlying cause given in Part I.  26. Place of Deathert 3 DOA	1   Yes  24a. Was an autopsy performed? 1   Yes 2   1   (Check only one)  ne 5   Residence	Month Day Year  Do use contribute to the cause of death?  2 \[ \text{No} \] 3 \[ \text{Probably} \] 4 \[ \text{Duwnown} \]  24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \text{Yes} \] 2 \[ \text{No} \]  6 \[ \text{Other} \( \text{Specify} \)
P.O. Box 68	Physicien: The law requires that the death certifica this certificate has been signed by the attending phal director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	Cause (Disease or injury that infitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	underlying cause given in Part I.  26. Place of Death  27. Other: 4 \( \text{Nursing Hor} \)  of 28c. Injury at Work?	1 Yes  24a. Was an autopsy performed? 1 Yes 2 (Check only one)	Month Day Year  Do use contribute to the cause of death?  2 \[ \text{No} \] 3 \[ \text{Probably} \] 4 \[ \text{Duwnown} \]  24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \text{Yes} \] 2 \[ \text{No} \]  6 \[ \text{Other} \( \text{Specify} \)
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P.O. Box 68	Physicien: The law requires that the death certifica this certificate has been signed by the attending phal director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that infitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	underlying cause given in Part I.  26. Place of Death 26. Place of Death ent 3 DOA Other: 4 Nursing Hor of 28c. Injury at Work? M 1 Yes 2 No street, factory, office	24a. Was an autopsy performed?  1 Yes 2 1 1 Yes 2 1 1 (Check only one)  me 5 Residence 28d. Describe how in City or Town, Sta	Month Day Year  Do use contribute to the cause of death?  2 No 3 Probably 4 Dunnown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify)  jury occurred  and Number or Rural Route Number, ite)
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / D	epa Cer	rtment of He tificate of D	ealth and Death	Mental Hyo	giene 2 (	004	16594
	Physici /Medic		Decedent's Name (First, Middle, Last	Pearl	E.	Н	ellman		2. Date of Dea Month May 20,	Day	Year	3. Time of Death 8:00 P <sup>M</sup>
S.	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or I	Location of Dear			y of Death	1 0:00 1
			Genesis Heritage				Dunda					re Co.
1	Funeral Director		225-22-3795	x 7. Ag	e (In yrs. last birt) 81	rs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day	Year) 6,1922		place (State or Foreign ntry) rginia
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Lo	cation				1	Od. Inside City Limits
	Mary I sh	ţō	Maryland Balt	imore				Dunda1k				1 ☐ Yes 2 ☐ XNo
	r 28g	irec	10e. Street and Number		1		10f. Zip Code	Dunaan		l0g. Citizen of	What Cour	ntry?
	23a c	rai D	18 Vista Mobile 1	Drive				2122	22	Unite	ed Sta	ates
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show amy injury or other traumatic event. The Madical Examinar must be inclified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates:		l If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 1 No	panic Origin? (S , Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)		ce - Americ ck, White, by:	
Ö	2 hou	ted	15. Decedent's Edu	cation	16a.	Deced	ent's Usual Occupat	ion		16b. Kind of B	usiness/Inc	
21215-0036	l within 7; iene. r then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 Years	e completed) College (1-4or 5	i+)	(Give I life. E	kind of work done du O NOT use retired) Maker	iring most of wo	rking		vn Hor	,
פַ	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Na	ne (First, Middle,			
<u>Ja</u>	Menta	ToE	Percy Smith					Rei	nee			
, Maryland	alth and 2 sho		19a. Informant's Name/Relationship (Ty Kenneth B. Stahl/S		19b. 2	Mailin 16	Address (Street ar. Briars Ru	nd Number or Ru In Drive	iral Route Numbel Downing	town,	State, Zip	Code) 9335
Baltimore,	of He of He fitem		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R	temoval from State	20b. Place of cemetery	Dispos	ition (Name of atory or other place)		Date	20c. Location	City or To	wn, State
Ĕ	Pag ment tent: I		4 □ Donation 5 □ Other (Specify)		Garden		f Faith C		24/2004			Maryland
Bal	permit Depar Impor any in	y y	21. Signally e of Funeral Service License	· Ca	ull	79	Name and Address Ca-Ruck F 22 Wise A	ve. Du	ndalk. M.	arvland	, Inc	2.
			23a Part Enter the disease, or compli snock, or heart failure. List only or	ications that caused ne cause on each lir	the death. Do no	ot ente	r the mode of dying,	such as cardia	or respiratory arr	est,		Approximate Interval Between
7	Pnysician	8 4	Immediate Cause (Final disease or condition resulting in death)	MALN	WIRIT	10	K					Onset and Death
	/Medical Examiner		Tooditing in docum	Due to (or as	a consequence of	,	-11 A-		10.00			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	$\mathcal{I}$	H AGI	74/1	OF			
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	RHAB	DAMYS	25	1515					
o	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence of	):	9					
68760,	ate by	edical		DREPS	7 64		<b>/</b>					
	certific ding p		IF FEMALE:	3c. If yes, outcome	of pregnancy							
O. Box	The law requires that the death certil the has been signed by the attending bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		ctopic pregnancy Other (specify)			23d. Da Mo	te of delive nth	ry Day Year
ls, P.O	res that tigned by	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the un	derlying cause given	in Part I.		_		e cause of death?
oro C	w require been sle should t	eted					<del></del>		1 Ye	s 2 No		
		Completed							24a. Was an autops perform	190 /	Were autoportor to com leath?	osy findings available appletion of cause of
<u>≅</u>	sicien certifi rector	Be	25. Was case referred to medical examiner?	ospital:			Other	/	th (Check only one			
ō	rthis raldi	7: To	1 Yes 2 No	1 🗀 Inpatiei			3☐ DOA 28c. Injury a		ome 5 Reside 28d. Describe ho			)
0	nding tth. :: Afte 9 fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) Inj	ury	Work? M 1 □ Ye			,,	-	
Division of	ospital or Attending Physicien: Theurs atter death. unerel Director: After this certifica	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, fam . (Specify)	n, stree	et, factory, office		28f. Location (Str City or Town	reet and Numb , State)	er or Rural	Route Number,
, ,	X 4 T 5	edicai C	29a. Certifier (Check only one) Certifying Phys	sician: To the best of ner: On the basis of and manner sta	examination and/	death or inve	occurred at the time, stigation, in my opin	date and place ion, death occur	and due to the ca rred at the time, da	use(s) and ma ite and place, a	nner as sta	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/ /			29c. License n	umber	29	d. Date signed	(Month, D	lay, Year)
	1		Minustan 1	( Kell	1/ M	2	02%	7/88		5/21	104	
	b		30 Name and address of person who con	mpleted cause of de	ath (Item 23a) (T	ype, P	rint) DI	·	1.00	1		
	/		The Mariner (Marin Day Van)	82. Registra	1960 Signatura	N	N SK	4/	ughtel	( M)	21	222
	Sta Registra		MAY 2 5 2004	Seneral Services	i s signature	1	parto					

			d Item		.11,	21,20	Ce	er me rtificate	e of l	Death	11/04	2. Date of		201	14	16 5 3. Time of	95
Physician			nn Irwin									Month MAY	21	, 200	Year 14	8:08	a M
/Medical Examiner			not institution, g		number)			4b. City,	Town, or	Location	of Death			. County o		0.000	
C	50	9 KENT	ROAD					GLI	EN B	JRNIE	:		A	NNE A	RUNE	EL	
Funeral Director		ocial Security No 9-94-02	1	Sex 1∭XM 2☐F	_	(In yrs. la 39	a <i>st birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.		Birth Day, Year -1964	)	Coun	lace (State o try) more,	
pue *	_	State	10b. County			10c. City	r, Town or Lo	cation							1	0d. Inside Ci	ty Limits
the Maryland 28a-f show notified at rector	MI	)	Anne Ar	undel		G1en	Burn	le							:	1 🗌 Yes	<b>≱</b> □ No
deeth with the ms 23a or 28a cmust be notified and interest Directors.	10e.	Street and Nun						10f. Zip						tizen of Wi	hat Coun	try?	
s 23a oust b	50	9 Kent	Road	12. Was De	andon C	luga in 11 i	C 12		061	i- Ori	ining /Co.	ait. Van ar		SA 14. Race	Amorio	an Indian	
P 2 2 2	11. 1	Marital Status Never Marrie □ Widowed	ed 2 Married	Armed	Forces? s 2∏N Give		i	was Deced if Yes, spec 1 ☐ Yes :		spanic On n, Mexicar Specify:		ecify Yes or Rican, etc.)	No-		, White,	etc.	
15-003 172 hours "natural", ulcal Exe	-	/Speci	15. Decedent's		d)			dent's Usua kind of wo			t of wadki	na	16b. F	Cind of Bus	siness/Inc	dustry	
21215-0036 ed within 72 hours ef yordine retrain "natural", or the worker Examit, to a Modical Examit Completed by F	EI	ementary/Secor			(1-4or 5	<b>+</b> )	life.	DO NOT us	se retired	)	i or worki	,,,9	C	onstr	noti	on	
d 21		12 Father's Name (	First, Middle, La	st)			Cal	penti	Ly	18. Mothe	er's Name	(First, Mide				.011	
Maryland 2121 the 2 should be filed withir file and Mental Hygiene. 77 is marked other than recommend event, the Maryland of t			eorge Ir							Pat	rici	a Ann	Po1a	nd			
Pary 2 shou and N is mar eumat			me/Relationship				19b. Maili	ng Address	(Street a			l Route Nu			itate, Zip	Code)	
ore, M as 1 and 2 of Health litem 27 i	_		Irwin	/ Broth	ner	205 81				ive M		iry, N			N		
DOLE IN THE STATE OF COLD		Method of Disp 1 ☐ Burial 2 5	7Cremation 3	☐Removal fro	m State	CE	lace of Dispo emetery, crea	natory or o	ther plac	θ)	May 20			ocation - C	•		
Baltimore, permit. Pages 1 a Department of Hez Important: if them any injury or othe once.	_		5 Other (Spen			Che	sapeal							vensv		n Buri	nia
Balt permit. Departr Importa		1	3	~	MO1	220						ome PA				and 2	
Physician /Medical Examiner   Exa	imm dise resu	shock, or hear lediate Cause (i ase or conditior ulting in death) uentially list cor y, leading to im ie. Enter Under so. Enter Under initiated events	nditions, mediate rlying njury	a. Olan Due t	n each line	ne I	ntoxic		·							Approximate Interval Bett Onset and I	ween
certificate be diding physicia se as the bur		EMALE: Was decedent in the past 12	pregnant	d. 23c. If yes, o	a birth 2	of pregnar 2	ncy death 3[	Ectopic pr						23d. Date		,	/ear
. 0 00		1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pre 9□ Unl	gnant at t known	time of de	ath 5	Other (sp	ecify)				-	WORK	u t	Day 1	oai
	Pan		cant conditions	_	death bu	t not resu	ulting in the u	nderlying c	ause give	on in Part I						e cause of d ably 4 ⊡U	
The law ate has be page 2 sh												24a. W au pe 1 Yes	topsy rformed?	pri	ior to con	osy findings an pletion of ca	available ause of
of Vital F Physicien: Th this certificate ral director, pag TO Be Col	25.	Was case referr		Hospital:					Otho			(Check on					
the second		IXYes 2□I Menner of Death □Natural		28a. Dai	□ Inpatier te of Injun onth, Day	Year)	ER/Outpatier 28b. Time o <b>Found</b>	_	8c. Injury Work			me 5 □ Ro 28d. Describ	e how inju			) SCE	NE
Division c To the Hospital or Attending P within 24 hours after death. 7 To the Funeral Director: After t completely filled in by the funeral Medical Certification:		2  Accident 3  Suicide 4  Homicide	6 X Could not determine	be 28e. Pla	704 ce of Inju Iding, etc. nd at	ry - At ho (Specify	me, farm, str			Α.		Unknov 28f. Location City or Len Bu	n (Street a Town, Stat		r or Rurai <b>ent</b>	Rd •	ber.
he Hospital n 24 hours a he Funerel I pletely filled edical Ce		Certifier (Check only one)	1⊡ Certifying 2X Medical Ex	Physicien: To t aminer: On the	he best o	f my knov examinat	wiedge, deat				nd place, a	and due to t	ne cause(s	) and man			)
To the within 2 To the comple		Signature and	title of certifier	me UK	ule	N	ND	290	: License				29d. Da	te signed	(Month, L		
Sal	30 1	Name and address	ess of person wh	o completed ca	use of de				enn S	stree	t, Ba	altimo	ore, l	Maryl	and	21201	
State Registrar	31. 1	Date filed (Mont	Day Year)	Luna 32.	Registra	r's Signa	ure	rock									

			1 For	State of Maryla	ınd / Dep	artme	nt of Health and ate of Death	•	ygien	_		16506
			Registrer  1. Decedent's Name (First, Middle, L	actl		Tunca	ile oi Dealii	0 Data of 5		o. C. U	U 4	10090
	Physici /Medio		Margaret	Α.			Jackson	2. Date of E Month May			Year 004	3. Time of Death 7:10a.M
4	Examir	ner	4a. Facility Name (If not institution, g	ive street and number)		4b. Ci	y, Town, or Location of Dea	th	4	c. County of	of Death	
			4400 Manorvie				timore					
	Funeral Director		5. Social Security Number 6.  215-46-5021  Usual Residence of Decedent	Sex   7. Age (In yr 1 □ M 2 \ F   55	s. last birthdey, Yrs.	Month	er 1 Year   If Under 24 Hr s Days Hours Mir	. (Month, I		48	9. Birthple Count V	ece (State or Foreign ny) A
	land		10a. State 10b. County	10c. (	City, Town or L	ocation		<del></del>			10	d. Inside City Limits
	Mary	ō	MD NA		Balti	more						XXYes 2 □ No
	1he 28a	Director	10e. Street and Number		Dartr		ip Code		10a C	itizen of W	hat Count	n/?
	3a or		1400 Managarian	Pood			21229		_			.,.
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumetic event, the Medical Examinat must be routified at	Funeral	4400 Manorview 11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was De		Specify Yes or N	1	U . S . /	- America	ın Indian
(0	riter	돌	1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Yes, s	edent of Hispanic Origin? ( becify Cuban, Mexican, Pue	rto Rican, etc.)	••		, White, e	
936	urs a	ğ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes	2 No Specify:			Specify:	R1	ack
21215-0036	72 hor	Completed by	15. Decedent's	Education	16a. Dece	dent's U	sual Occupation		16b.	Kind of Bus		
215	within 7 ene. than "n	pie	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Give	DO NOT	vork done during most of we use retired)	orking				,
21,	filed with Hygiene. Ither than	E	12th grade	2vrs	н	ouse	wife			Но	ne	
	illed Hygi other	Be	17. Father's Name (First, Middle, Las					me (First, Midd	le, Maide			
ā	ould be Mental varked o	To B	James W. Rober	tson			Martha	Willi	ams			
Maryland	2 should be and Mental is marked c raumatic eve	-	19a. Informant's Name/Relationship		19b. Mail	ing Addre	ss (Street and Number or F			or Town, S	state, Zip (	Code)
Σ	nd 2 lith a 27 is r tra		Frank Jackson	-Husband			orview Roa					21229
ē,	s 1 a f Hei item othe		20a. Method of Disposition		Plece of Dispe	osition (A	ame of	Date		ocation - C		
Baltimore,	permit. Pages 1 and : Department of Health Important: If item 27 any injury or other tr. <u>once</u> .		XIXBunal 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec		cemetery, cre							
₽	nit. Parantarininjury		21. Signature of Funeral Service Lice	ensee.	dar H	ill 2. Name	Cemetery 5	/27/04	Gl	en Bi	urni	e, Md
Ba	permit. Departr Imports any inj		Min	2 de l	M	arch	F7H West					
			23a Perti Enter the disease or co	molications that caused the de	ath Do not en	300	Wabash Ave	, Balt	imo	re Mo	3 2	1215 Approximate
			23a. Pert . Enter the disease, or conshock, or heart failure. List only	y one cause on each line.	<u></u>	/)	oue or dying, such as cardia	ic or respiratory	arrest,			Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Conges	live	he	ul failu	re			i	aulain
	/Medical Examiner		1	Due to (or as a cons	equence of):	,	4-					14
н		<u>.</u>	Sequentially list conditions,	b. Carde	ac a	Mh	junica					3 month
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	A	. (	1					
	and and I-trar	хап	that initiated events resulting in death) Last	c. Due to be as a cons	cus (	on						12 year
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687	cate physi the		1	d								
9 ×	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:	220 16 100 0 100 0 100	LIE.		· · · · · · · · · · · · · · · · · · ·					
Box	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1☐Live birth 2☐Fe	itel death 3[		pregnancy			23d. Date Mont		y Day Year
_	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other	specify)		į			, , , ,
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Records,	res t	Ď	Part II. Other significent conditions	contributing to death but not n	esulting in the t	mueriying	cause given in Part I.					cause of death?
oro	pinoi pould	ted						1	Yes 2	NO S	Proba	biy 4 □Unknown
ec	law as b	Completed						24a. Wa	s an	24b. W	ere autop:	sy findings available pletion of cause of
	The ate h	, o						per 1 ☐ Yes	formed?	de	ath? Yes 2	
Division of Vital	ian: ortific ctor,	Be (	25. Was case referred to medical examiner?				26. Place of De	ath (Check only				
<b>~</b>	aysic lis ce dire	To	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 🗆 I	OOA Other: 4 Nursing	Home 5 146	sidence	6 Other	(Specify)	
٥٦	ig Pt ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	ıf	28c. Injury at Work?	28d. Describe				
Ö	ath. r: Af	atio	1 Natural 5 Pending 2 Accident investigation		Піјату	M	1 ☐ Yes 2 ☐ No					
Vis.	Atte	Certification;	3 Suicide 6 Could not	289. Place of injury - At	home, farm, st	reet, facto	ory, office	28f. Location	(Street a	nd Number	or Rural	Route Number,
ō	s after	Ser l	Tomicide /	building, etc. (Spec	Juy)			City or To	own, Stat	θ)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying F	hysician: To the best of my ki	nowledge, deat	h occurre	d at the time, date and plac	e, and due to the	e cause(s	and man	ner as sta	ted.
	ne Hd	Medical	(Check only 2 Madicel Exa	miner: On the basis of examinand manner stated.	nation and/or in	vestigation	n, in my opinion, death occ	urred at the time	, date an	d place, ar	d due to t	he cause(s)
	To the within To the Comp	Ž	29b. Signature and title of certifier	11 40		2	9c. License number			ate signed		ay, Year)
	1		Rain S. Kang	mem M.D			D26307		5	/21	104	
	10		30. Name and address of person who		em 23a) (Type							
	Ψ		RANI S. KARIPINE	NI 202 W. 1	LAPLO	FR	D, LINTHI	CUM,	HD	210	90.	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature 4	do	2/1					
	Registi		31. Date filed (Month, Day, Year) MAY 2 5 20	04	10	payer	nas					

		State of Manyland / Department of H		-	•	
		State of Maryland / Department of Honor State of Maryland / Department /			2001	1000
		1. Decedent's Name (First, Middle, Last)	Jeaui	2. Date of Death	. No. 2 1 1 4	13 time of Beath
Physicia	an	Helen Virginia Jewett		Month May 20,	Day Year 2004	7:31 PM
/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death	riay 20,	4c. County of Death	,,,,,,
Examin	er	Heartlands of Severna Park Severna	Park		Anne Arun	de1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthi	plece (Stete or Foreign ntry)
Director		215-76-1369 1□ M 21 91 Yrs. Months Days	nours Min.	Oct 4, 1		imore, MD
P .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
anyla ehov	>	MD Anne Arundel Glen Burnie				1 ☐ Yes 21 No
he M	ect	10e. Street and Number 10f. Zip Code		100	. Citizen of What Cou	
with Ber	급	7539 Baltimore & Annapolis Blvd. N.E. 21060		109	USA	w.y.
ne 23	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His	spanic Origin? (Spa	cify Yes or No-	14. Race - Ameri	can Indian,
riter	표	1 Never Married 2 Married 1 Yes 2 🕅 No		Rican, etc.)	Black, White,	
el', o	þ	3 Mg Widowed 4 □ Divorced If Yes, Give Year or Dates:	Specify:		Specify: Whi	.te
72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupa (Specify only highest grade completed) (Give kind of work done do	luring most of worki	ng 16	b. Kind of Business/In	dustry
Athin ne. hen	du	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	)		Own Home	
tygier her ti		12 Homemaker  17. Father's Name (First, Middle, Last)	18. Mother's Name		-	
tal H	Be		Helen Lie		uen sumame)	
J Mer J Mer nark	Jo	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street a			itu or Tourn State 7in	Codel
d 2 si th an 17 is r		Mr. Charles E. Jewett / Son 497 Denington				
1 an Heal tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of	; D		c. Location - City or To	
ages ant of at: If i		1♥ Burial 2 □ Cremation 3 □ Removal from State  '4□ Donarion 5 □ Other (Specify)  Cemetery, crematory or other place  Meadowridge Memori	Mav 2	24 2004 E1	kridge, MI	)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be notified at once.		21. Signalare of Funeral Service Licensee 22. Name and Address				
Deparent Deparent Important in seny ir		M01220 I Second Av				
4 - SIVE		23a. P.m. Enter the diseast complications that caused the death. Do not enter the mode of dying shock, or heart failure. Ost only one cause on each line.	, such as cardiac o	r respiratory arrest		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition a Congestive he	art	fail		Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of):		7 000	are	year s
Examiner		Saquentially list conditions b.				
pe tis	Iner	if any, leading to immediate Due to (or as a consequence of):				
be executed ician and burial-transit	Examln	Cause (Disease or injury that initiated events c.  Due to (or as a consequence of):				
	alE					
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the toget.	0	d				
certif nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
death a atte	cial	in the past 12 months?  4 Pregnant at time of death  5 Other (specify)			Month	Day Year
t the cy the acher	hys	9 ☐ Unknown				
n requires that the de been signed by the s should be detached	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	n in Part I.	23e. Did tobac	co use contribute to the	
equire en siç ould b	ed	Alzheimer's dementia		1 ☐ Yes	2 □ No 3 □ Prob	pably 4 Unknown
law re as be 2 sho	piel			24a. Was an autopsy		psy findings available mpletion of cause of
The ate h page	Completed by			performed 1 ☐ Yes 2 ☑	death?	2 □ No
cian: ertific ector,	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		Assited
hysi this c	은	1 Yes 2 DM Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	4   Nursing rion	ne 5 Residenc		niving
After Uner	ion:	27. Manner of Ceath  1 Natural 5 Pending (Month, Day Yeer)  1 Natural 5 Pending (Month, Day Yeer)  28. Date of Injury 28b. Time of Injury Work  1 Natural 1	at ? ′es 2 □ No	8d. Describe how	injury occurred	0
death death tor: the f	icat	3 Suicide 6 Could not be 380 Place of Injury. At home farm street featons office		98f Location (Stree	t and Number or Rura	I Route Number
for A after Direct	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	tate)	7710410 77311301,
spita nours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time	e, date and place, a	nd due to the caus	e(s) and manner as s	lated.
To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my op and manner stated.	inion, death occurre	d at the time, date	and place, and due to	the cause(s)
To the To the Comp	ž	29b. Signature and title of certifier 29c. License			Date signed (Month,	
į			50725	)	5-21-	2004
W		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	n	1/1000	ille, m	1) 21110
		31. Date filed (Month, Day, Year) 32. (Begistrar's Signature	Ticky!	1100131	· ce vi	0 411 08
Sta Registr		31. Date filed (Month, Day, Year)	1			
5.00		MAY 2 5 2004 Samuel 15 Apacen				

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

# unpend item#23a,Part II,27,28a-f,PFR ME,0332,6/9/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	an	1. Decedent's Name (First, Middle, I William Jenk	,				2. Date of Death Month MAY 12,		Year	3. Time of Deat
/Medic xamin		4a. Facility Name (If not institution, g	rive street and number)		4b. City, Town,	or Location of Death		4c. County	of Death	3.30 1
		1401 MYRTLE A				ORE CITY			N/A	
neral ector	7	5. Social Security Number 6. 214-84-4034 Usual Residence of Decedent	.Sex 7. Age 1 X M 2 □ F 39	(In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, 102-09-19	Year) 165		place (State or Fore htry) yland
any injury or other traumatic event, the Medical Exertiner must be redified at once.	ctor	MD 10b. County NA		10c. City, Town	or Location Baltimore				1	0d. Inside City Lin 1   Yes 2   □
PE DE	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of V	What Cour	itry?
TAMES	eral	3130 Normant Ave	enue 12. Was Decedent Ev	uor in II C	212			US		
var irec	by Funeral Director	1 Marrial Status  1 Marriad 2 Marriad  3 Widowed 4 Divorced	Armed Forces?		13. Was Decedent of I If Yes, specify Cub		Pecify Yes or No- Pican, etc.)			etc.
ical	ted	15. Decedent's I	Education	16a.	Decedent's Usual Occup	pation	16	6b. Kind of Bu	Blac usiness/Inc	
the Med	Completed	(Specify only highest g	College (1-4or 5+	)	(Give kind of work done life. DO NOT use retire Laborer	during most of work	king		ehous	
event	Be	17. Father's Name (First, Middle, Las				18. Mother's Nam	e (First, Middle, Ma	iden Sumam	е)	
atic	<sup>c</sup>	William Jenkins				Judy A.	Stuart			
traun		19a. Informant's Name/Relationship Judy A. Stuart/ M			Mailing Address (Street					Code)
ther		20a. Method of Disposition	TOTHEL		O Normant A		The state of the s			
y or o	2	1 X Burial 2 ☐ Cremation 3		1 .	Disposition (Name of c, crematory or other plan	1		c. Location -		
injur.		' 4 □ Donation 5 □ Other (Spec	* *	Mt. 21	on Cemetery 22. Name and Addre		4-04 L	ansdow	ne, M	ID .
any ir		1 hours	11/1/11/2		Wylie Fune		638 N C	ilmor (	C+ 12	olto Mi
4.	1					Tur Home	050 M. G.	T TIMOL I	OL. D	allo, P
cian .		23a. Part. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that caused the yone cause on each line  Narcotic Li		ot enter the mode of dyir	ng, such as cardiac	or respiratory arrest	d,		Approximate Interval Between
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DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of M		Dep		t of H	ealth a		lental Hyg	iene	004	16599
	ysicia	ın	1. Decedent's Name (First, Middle, La Huber	t John Ka	aempf						2. Date of Deat May 18,	n 2004	Year	3. Time of Death 5:45 P. M
Ex	ledica amine	er	4a. Facility Name (If not institution, giv  Northampton N 5. Social Security Number 6. S	lanor Nurs				E	Location of reder	ما ماء	8 Date of Birth		ty of Death	
Fund Direct	ctor		398-12-8154  Usual Residence of Decedent	₩ 2□F	84	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Day, Februar	y 12,		lace (State or Foreign Wisconsin
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "natural", or Items 23a or 28a-f show	t be notified at	ctor	,	ederick Orive	10c. City, To	wn or Lo		code	ick 2170	)2	11	Og. Citizen o		
036 urs after death al', or Items 23	Examinermus	۾	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 ∰ Yes 2 ☐ If Yes, Give Year or Dates	?  No   1943 t		Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americack, White, o	an Indian,
Maryland 21215-0036 at 2 should be filed within 72 hours aff the and Mental Hygiene.	I've Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation de completed) College (1-4o	1945 16 (5+) Ch	a. Dece (Give life. 101	dent's Usua kind of wor DO NOT us OI IS	il Occupa k done d se rejired) CLL1	tion uring most ties	of worki	ntenance	16b. Kind of U.		<sub>vernment</sub>
yfand yfand buld be file Mental Hy	atic event	To Be	17. Father's Name (First, Middle, Last, Urvin Oliver Ka	empf					Ma	atilo	da Augus	ta Des	tinon	
e, Mar 1 and 2 shi 1 ealth and 1 m 27 is m	ther traum	-	19a. Informant's Name/Relationship ( RONald Hubert Kae	** * * * * *		829	Rocky	Spr		Road	d Route Number, d, Frede	rick,	MD 21	702
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked	any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer  21. Signature of Funeral Service Licer  23a. Part1. Enter the disease, or complete shock, or heart failure. List only	soft D	* Freder	i.ck	Memor Name an	ial d Address	Park o Facility	May	22, 200	TT	ederic	k, MD
Priysio /Medi Exami	ical		disease or condition resulting in death)	a	ed the dear. De line	101	4 I C.V	e of dying	, such as o	ardiac o	r respiratory arre	uc V		Approximate Interval Between inset and Death
68 / 60, ilicate be executed g physicien and	ng en	cai Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequenc									
SOX ath cert	iched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		e of pregnancy 2 ∐ Fetal dea at time of death		Ectopic pro				-111		ate of deliver	ry Day Year
cords, P.O. I w requires that the de been signed by the a	e .	Š	Part II. Other significant conditions of	ontributing to death	but not resulting	in the u	nderlying ca	ause givei	n in Part I.		23e. Did tob	-		e cause of death?
Rec The law	or, page 2 sh	e Completed	25. Was case referred to medical	ofester	oler	711	1		26 Place	of Doath	24a. Was an autopsy perform 1 Yes 2	ed? No	Were autop prior to con death? 1  Yes	osy findings available npletion of cause of 2 No
th y	tuneral direct	10 B	examiner?  1 Yes 2 Yes  27. Maner of Death  1 Matural 5 Pending  2 Accident investigation	Hospital: 1 Inpat 28a. Date of In (Month, D	ury 28b	Outpatier Time of Injury		Bc. Injury Work	r: ur:	sing Hor	ne 5 Resider	nce 6 Ot	-	)
DIVISION C let or Attending P is after death.	ed in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At home, etc. (Specify)	farm, str	eet, factory	office		2	28f. Location (Str City or Town,	eet and Num State)	ber or Rural	Route Number,
the Hospi thin 24 hour the Funer		edicai	29a. Cartifier (Check only 2 Medical Examone)  29b. Signature and title of certifier	ysician: To the bes niner: On the basis and manner s	or examination a	ge, deatl ind/or in	vestigation,	at the time in my opi	nion, death	place, a occurre	ed at the time, da	use(s) and made and place	and due to	the cause(s)
	3		30. Name and address of person who			) (Type,	Print)	D164	28			5/2	0/0	4
Do	Stat	e	Casper E. Cli	ne III, N	1.D., 30 trar's Signature			nth	Stree	et, I	Frederic	k, MD	21701	1
DHMH 17 Re	gistra ev 1/200	195	MAY 2 5 200	Bue	OF	g RIGIN	AL	en						

State of Maryland / Department of Health and Mental Hygiene 2004 16601 State Registra-AMEND TIEM #23a&b PER PHY 0831 5/25/Operatificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY NATALIE LAPIDUS **Physician** 9, 2004 4:08 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV.15,1952 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1□M 2∏F 212-60-6280 51 **Director** MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b Counts s 23a or 28e-f ehow 1 ☐ Yes 2 🙀 No Completed by Funeral Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11913 HUNTING TWEED DRIVE 21117 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+ Elementary/Secondary (0-12) TEACHER BALTIMORE CITY SCHOOLS Ith and Mental Hygis 27 is marked other r treumatic event, iii 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be inent of Health and Mental out: If item 27 is marked o BLAUSTEIN ANNA BAUM SAMUEL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health a: If item 27 is MARK LAPIDUS / HUSBAND 11913 HUNTING TWEED DRIVE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department of Importent: If any injury or once. BETH JACOB CEMETERY 5/10/2004 FINKSBURG, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. luncan 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNELMONIA 8 DAYS /Medical Due to (or as a consequence of): Examiner PULMONARY HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Year 5 Other (specify) 4□Pregnant at time of death ed by the detached o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? After Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL, TOWER 110, 600 NORTH WOLFF ST. BALTIMORE MD BOREK, PETER 2. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 2 2004 racket Registrar

			For State Registrar	State of Marylan	d / Depa	artme		th and M	•	/giene_	004	16602
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)     John Michael     Aa. Facility Name (If not institution, give s	Lambros street and number)			, Town, or Loca	tion of Death	2. Date of D Month May	Day 23,	2004 ounty of Death	
	Funeral Director		235 S. Clinton S  5. Social Security Number 217-14-9846  Usual Residence of Decedent	7. Age (In yrs.	last birthday) 4 Yrs.	If Unde Months			8. Date of B (Month, D March	rth ay, Yeer) 20,192	9. Birth 20 G	d oplace (State or Foreign untry) CPECE
	72 hours after death with the Maryland natural', or items 23a or 28a-f ahow dical Exerciper cust be motified at	Funeral Director	10a. State         10b. County           Maryland         n/a           10e. Street and Number         235 S. Clinton State	В	y, Town or Lo altimo	re	p Code 212	224		-	n of What Co	
036	be filed within 72 hours after death with the Manylan Ital Hygiene. od other than "natural", or Hems 23a or 28a-f ahow avent, the Medical Exercities must be publised at	by		12. Was Decedent Ever in U. Armed Forces? 1   Yes 2   Xi No If Yes, Give Year or Dates:		Was Dece If Yes, spen 1 Yes	edent of Hispani ecify Cuban, Me		ecify Yes or N Rican, etc.)	0- 14.	Race - Amer Black, White	
Maryland 21215-0036	filed within 72 ha Hygiene. other then "natu	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) Unknown 17. Father's Name (First, Middle, Last)	cation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usi kind of w DO NOT Pain			ing (First, Middle			ndustry Company
Marylan	s 1 and 2 should be Health and Mental Itam 27 is marked cother traumatic ave	To Be	Michael Lamb 19a. Informant's Name/Relationship (Ty), Mrs. Mary Lambros	оө, Print)	1		s (Street and No.					ip Code) 1224
Baltimore,	permit. Pages 1 ar Department of Hea Important: if Itam any injury or other once.	17/	20a. Method of Disposition  1	emoval from State Gre	lace of Dispo emetery, cren ek Ort	sition (Na natory or hodo: . Name a	me of other place) X Cem. nd Address of F	May 26	5,2004	20c. Local WOO 5305 H	tion-City or 1 dlawn, larford	Town, State Maryland Road
	Physician /Medical		23a. Pert1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	calions that caused the death e cause on each line.  Due to (or as a consequence)	real	er the mo	nard J.  de of dying, suc	h as cardiac d	or respiratory a		ore, M	Approximate Interval Between Onset and Death
760,	icate be executed by social and burial-transit buri	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)								
P.O. Box 687	death certif e attending ed for use a	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of do	Ideath 3	Ectopic p	regnancy pecify)			23d	d. Date of delik Month	rery Day Year
	requires een sign	eted by Pt	Part II. Other significant conditions con	tributing to death but not rest	ulting in the ur	nderlying	cause given in F	Part I.	10	Yes 2□N	contribute to	the cause of death?
Division of Vital Records,	The la ate has page 2	Be Completed	25. Was case referred to medical examiner?				26. F	Place of Death	24a. Was auto perfi 1 Yes	psy prmed? 200 No		opsy findings available ompletion of cause of
ion of V	ding Phys h. After this funeral di	2	1 Yes 2 No H  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1	ER/Outpation 28b. Time of Injury		OA Other: 4 [ 28c. Injury at Work? 1 □ Yes	1	ne 5 Res 28d. Describe			ify)
Divis	To the Hopginal or Attending within 24 hobs after death. To the Funeral Director: Attercompletely filled in by the fune.	al Certification:	3 Suicide 4 Homicide  29a. Certifier  29a. Certifying Phys	28e. Place of Injury - At he building, etc. (Specify ician: To the best of my known in the best of my	v) wledge, death	OCCUITA	at the time, dat	e and place	City or To	wn, State)	d manner as	al Route Number,
	To the Ho within 24 to the Fu completely	Medical	(Check only 2 Medical Examination)  29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	tion and/or inv	estigation 29	c. License numl H 43 2	death occurre ber	ed at the time,	date and pla	igned (Month,	to the cause(s)
	5		30. Name and address of person who con  DAVID SILVERT  31. Date filled (Month Care Year)		susta		Av,	Balt	-1 m 07	re po	ref 2	1224
	Sta Registr		31. Date filed (Month, Oay, Year) MAY 2 5 200		4							

ORIGINAL

DHMH 17 Rev 1/2001

MAY 2 5 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician Islav F. Macfarlane MAY 12:10 PM 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Center Towson Baltimore H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye)
Months Days Hours Min. May 12, 1 5 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6 Sex **Funeral** 1□M 2X F 164-46-7377 51 Director 1953 New Jérsev Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. Count or 28e-f show 7 is marked other than "naturel", or Items 23a or 28e-f shov treumetic event. The Mcdcal Examina must be multified at 1 ☐ Yes 2 X No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2306 Chetwood Circle # 302 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1K Yes 2□ No Specify: Cuban Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Psychologist Psychology 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked o William Macfarlane Winifred Seymour 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an item 27 i Lindsay Eastwood daughter 110 W. 39th St.; Baltimore, MD 21210 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Importent: If it eny injury or o 4 Donation Hilltop Service Corp. 5/26/04 5 Other (Specify) Towson, MD 21. Signature of Funeral Service Ligense 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications of at ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, in each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC RENAL CELL CARCINOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-transit attending physician and c Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai d IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year ò 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ρ Division of Vital Records, 99 DIABETES INSIPIDUS 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 performed: 1 Yes Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 1 🗌 Yes 2X No this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation 1 X Natural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 37254 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM. 7601 OSLER DRIVE. TOWSON. MARYLAND 21204 M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State south Registrar MAY 2 5 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 632 AM Hattie <u>McCullers</u> Ma-2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimere Cit If Under 1 Year If Under 24 Hrs. Hospital 25 Baltimore 8. Date of Birth (Month, Day, Year) 12–16–21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□ M 🎾 F Yrs. 213-32-8335 Director 82 N.Carolina Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits rai', or items 23a or 28e-f show Examiner must be notified at 1 XYes 2 No Completed by Funeral Director Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4016 Buckingham Rd 2120712. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X No Specify: Black 3 ☐ Widowed 4 🎇 Divorced the Mudicul 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed with and Mental Hygiene. 12 Homemaker Home marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Tucker Elize Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 24 Brook Terrance Rd. Glen Burnie Md. Geraldine McCullers Baltimore, Hen 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Importent: if it any injury or o o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 Donation 5 Dother (Specify) Mt. Zion Cem. 5-26-04 Lansdrowne, Md. 21. Signature of Funeral Service Licensee Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by th Sion 2 No 3 Probably 4 Unknown 1 Tyes page 2 should 24a. Was an autopsy performe Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 2 No 1 Yes Division of Vital Hospitei or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours af To the Funerel D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 May 20 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

1K Scha S 31. Date filed (Month, Ox, Year)

MAY 2 5 2004

Sinai

Hospital

32. Registrar's Signature

ttie McCullers

FP

0

Baltimore

Anna M. Maggitti 04-03358 cm

umpend item#23a,Part II,27,28a-f,PER ME,0833,7/2/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 2004							
-	For State Registrar	Certificate of Death		۔۔۔ ی No.	004	166	OUD	
1. [	Decedent's Name (First, Middle, Last)		2. Date of Death		V	3. Time of I		
	Anna Maria Mag	zitti	Month	18	2004	8:58	РΜ	

Physiciar /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "netural", or Items 23a or 28e-f show eny highry or other treumetic event, its Medical Exament must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Anna Maria Maggitti				May	18 :	2004	8:58	РМ
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		th	4c. County			
Johns Hopkins Bayview Medica		Baltim				N/A		
1 N W	,,//_	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	h y, Year)	<ol> <li>Birthpl Count</li> </ol>	ace (State or try)	Foreign
218-82-6818	31 Yrs.			April 1	5, 1973		MD	
Usuel Residence of Decedent  10a. State 10b. County 10	c. City, Town or Loca	ation				10	Od. Inside City	Limits
							1 🗆 Yes	
MD Baltimore	Essex	10f, Zip Code			10g. Citizen of V	Vhat Coun	tn/2	
							uy:	
41 Nerbay Road  11. Marital Status 12. Was Decedent Ever	rin U.S. 13 W		221 ispanic Origin? (9	Specify Yes or No		SA e - America	an Indian	
Armed Forces?  1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No		Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		k, White, e		
3 ☐ Widowed 4 ☐ Divorced	10	□Yes 2∏ No	Specify:		Specify	. Whi	te	
15. Decedent's Education	16a. Decede	nt's Usual Occup	ation		16b. Kind of Bu	siness/Ind	ustry	
(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or 5+)	life. DO	na of work done o O NOT use retired	turing most of wo	rking				
12 N/A	Nurs	ses Aid			Heal	lth		
17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Sumam	ю)		
Ronald F. Maggitti			Cathe	rine P.	Allen			
19a. Informant's Name/Relationship (Type, Print)				ural Route Numbe		-	Code)	
Ronald F. Maggitti/Father	The second secon	McCormic	k Ave.	Baltimor				
20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State	Ob. Place of Disposit	tion (Name of story or other place	e) May	Date 24	20c. Location -	City or To	wn, State	
* 4 □Donation 5 □ Other (Specify)	cemetery crema Dulaney Va Memorial (			004		onium		
21. Signature of Fundar and iceus a	22. L	Name and Addres	s of Facility	me of Du	lanev Va	allev	. Inc.	
Michael J.	ragie [	) W. Pad	onia koa	a limoni	um, MD	2109	3	
23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter	the mode of dyin	g, such as cardia	c or respiratory ar	rest,	İ	Approximate Interval Betw	een
Immediate Cause (Final disease or condition Acute alcoho	l intoxicati	ion complia	cating sei	zure disor	der		Onset and D	eath
resulting in death)  Due to (or as a co	onsequence of):						-	
Sequentially list conditions, b.								
Tany, leading to inmediate cause. Enter Underlying Cause (Disease or injury)	я гонция гон от у:							
that initiated events c. Due to (or as a co	onsequence of):					-		
555 15 (6) 25 2 3	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					- 1		
d								
IF FEMALE: 23c. If yes, outcome of p	regnancy				-			
in the past 12 months?	Fetal death 3 E	ctopic pregnancy Other (specify)			23d. Dat	e of deliver nth	,	ear
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	90109411 501	other (specify)						
Part II. Other significant conditions contributing to death but no	ot resulting in the und	derlying cause give	en in Part I.	23e. Did to	bacco use conti	ribute to the	e cause of de	ath?
Fatty Liver					′es 2 □ No		ıbiy 4. ☑Ur	
			<del></del>					
				24a. Was autop	SV C	rior to con leath?	sy findings a opletion of ca	use of
) 6				1 🔀 Yes	2 □ No   1	Yes	2□ No	
25. Was case referred to medical examiner?  Hospital:	o.Wente	3□ DOA Cth	DF:	ath (Check only o				
27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3☐ DOA 28c. Injun	4 🗀 Nursing i	Home 5 ☐ Resid	lence 6 □Othe now injury occurr		)	
1 Natural 5 Pending 5/18/04 Town	and Indiana	Worl	√? Yes 2 <b>∑</b> No	unknown	ion injury coodin	00		
a E a					Street and Number	er or Rural	Route Numb	er.
4 Homicide  3 Suicide  4 Homicide  4 Homicide  4 Substitution of Injury building, etc. (5)  4 Tound at hour		, , , , , , , , , , , , , , , , , , , ,		City or Tow	m, State)			,
	y knowledge, death o	occurred at the tin	ne, date and place	e, and due to the	cause(s) and ma	nner as sta	ated.	
29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or inve	stigation, in my o	oinion, death occi	urred at the time,	date and place, a	and due to	the cause(s)	
29b. Signature and title of certifier		29c. License	number		29d. Date signed	(Month, E	Day, Year)	
Jaske B Greenbe	ig MD		O.C.M.	E. 1	May 19,	2004		
30. Name and address of person with completed cause of death	(Imm 23a) (Type, Pr	rint)						
Tasha Z Greenberg M			reet, B	altimore	, Maryla	and 2	1201	

State

Registrar

31. Date filed (MMA Pay 2 ear) 2004

Coule

32 Redistrar's Signature

			For State Registrar	tate of Ma	ryland / Depa			ental Hygi	_	L 16607
	Physicia		1. Decedent's Name (First, Middle, Last)  Walter Robert Mill	er Sr				2. Date of Death Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, or t		1.1.1.1	4c. County of	
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yas. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Nov. 02	ANNE	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		81 Yrs.			Nov. 02	,1922   F	ennsylvania
	Marylar I show	tor	PA Perry		Shermans					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the a or 28s	Funeral Director	10e. Street and Number 4 Kenmar Drive			10f. Zip Code 17090	n	109	g. Citizen of Wha	at Country?
	r death tems 23 er munt	ınerai	11. Marital Status 12.	Was Decedent E Armed Forces?		Vas Decedent of His Yes, specify Cuban		cify Yes or No-	14. Race -	• A •  American Indian,  White, etc.
6 P	ours afte ral', or It Εναπίμ	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1√2 Yes 2 □ N If Yes, Give Year or Dates:1	943-44	N/	Specify:	,	Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Madical Examirar must be multied at	Completed	15. Decedent's Education (Specify only highest grade continuous)  Elementary/Secondary (0-12)	on m <i>pleted)</i> Colle <b>ge</b> (1-4or 5-	(Give	lent's Usual Occupat kind of work done du DO NOT use retired)		ng 16	6b. Kind of Busir	ess/industry
3 2	be filed with that the other the ovent, the ovent, the		17. Father's Name (First, Middle, Last)	2	-/	accounta	ant 18. Mother's Name			Richfield
しらと, ( Maryland	Q 5 0 9	To Be	Carl Frederick Mil				Etta Ger	trude Sh	nuster	
3	nd 2 salth ar		19a. Informant's Name/Relationship (Туре, Mr. Walter R. Miller			g Address (Street an ountry Dr				
More,	2 -		20a. Method of Disposition 1	oval from State	20b. Place of Dispo cemetery, cren Chesapeak	sition (Name of natory or other place)			c. Location - Cit	
Baltir	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	_	22	. Name and Address	of Facility Sin	gleton F	uneral	Home P.A.
	40140		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one c	ons that caused	the death. Do not ent	Second Average the mode of dying,				MD 21061 Approximate Interval Between
-0	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	SUBAR	ACHINOID	1-11-1	MORRH	ACE		Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate		consequence of):					<u></u>
V	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					2
760,	te be executed ysician and te burial-transit	icai Ex	resulting in death) Last	Due to (or as a	consequence of);					
Box 68760	eath certificat attending phy I for use as the		IF FEMALE:	If yes, outcome of	of pregnancy					
). Bo	the Hospital or Attending Physician: The law requires that the death certificate be executed nin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
s, P.O.	res that the de igned by the a be detached f	by Phy	Part II. Other significant conditions contrib	uting to death bu	t not resulting in the u	nderlying cause given	in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
Division of Vital Records,	w require been sig should b	eted !								Probably 4 Winknown
l Re	an: The fav rtificate has tor, page 2	Completed						24a. Was an autopsy performe	ed? prio	e autopsy findings available to completion of cause of th?  Yes 2 No
f Vita	ysiclan: is certific director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hosp	ital: 1 🗌 Inpatier	nt 2 ₩ER/Outpatien		26. Place of Death 4 □ Nursing Horn		ce 6 ∏Other (	Specify)
o uo	ding Ph h. After th funeral		27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	8a. Date of Injury (Month, Day		28c. Injury a Work?	at 2	8d. Describe how		
Jivisi	or Attendii ifter death. Director: A in by the fu	Certification:	all author	8e. Place of Inju building, etc.	ry - At home, farm, stre . (Specify)			8f. Location (Stre City or Town,	et and Number o State)	or Rural Route Number,
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	ledical Ce	29a. Certifier 1 Certifying Physicia Check only 2 Medical Examiner:	an: To the best of	f my knowledge, death	occurred at the time	, date and place, a	nd due to the cau	se(s) and manne	or as stated.
	To the h within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stat	ed.	29c. License r				fonth, Day, Year)
	6		0000	Lun	M D		55973		My 2.	2,2004
-	1.		30. Name and address of person who complete Desce	11500	sutherla	nd Hill	noy	Cilver	spring	Mb 20904
- 1	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 5 2004	32. Registra	r's Signature	rocke				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

***************************************	6	6	0	8
a	400	~	1	No.

/Medic	al
Funeral	•
	Physicia /Medic Examin

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or itams 23a or 28e-f ahow any njury or other treumatic event. The Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

<ol> <li>Decedent's Name (First, Middle, Last</li> </ol>	t)	Ce	rtificate of Death	2. Date of	Reg. N	0.	2 Time of Death
	P. MILLIGAN			Month	Da		3. Time of Death
la. Facility Name (If not institution, give			4b. City, Town, or Location of Death	MAY		5, 2004 c. County of Deat	2:59 P.
ORTHWEST HOSPITAL	CENTER		RANDALLSTOWN		E	BALTIMORE	<b>Ξ</b>
193-44-818/	7. Age (in ) M 2 F 47	vrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of 1 (Month, 11 – 2	Birth Day, Year	9. Birth	nplace (State or Fore untry) LA, PA
Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limi
PA DELAWARE		UPPER	DARBY TWP.		T		1 ☐ Yes 2 🔀 1
10e. Street and Number 5227 SPR	INGFIELD ROA	D	10f. Zip Code 19018		10g. C	itizen of What Col	untry?
11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2  No Specify:	pecify Yes or o Rican, etc.)	No-	14. Race - Amer Black, White Specify:	
15. Decedent's Edi (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupation kind of work done during most of wor	tina	16b. I	(ind of Business/	
Elementary/Secondary (0-12)	College (1-4or 5+)	life.	ICK DRIVER	Kiriy	7	reamster (	
17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Midd	lle, Maide	n Sumame)	
GEORGE W. MII				M. HEF			
19a. Informant's Name/Relationship (T) SARA M. MILLIGAN	Type, Print)  DAUGHTER		ng Address (Street and Number or Ru 27 CDDTN GFTFIN D				
Oa. Method of Disposition	20	b. Place of Dispo	27 SPRIN GFIELD R	Date	7	.ocation - City or 1	
BBBB 2 Cremation 3 III	Removal from State	SS. PETE	matory or other place) R & PAUL CEMETERY		04	MARPLE	TWP.,PA.
1. Signature of Funeral Service Licens	2 (160		2. Name and Address of Facility Da				
3a. Part1. Enter the disea of comp shock, or heart failure. List only of	plications that caused the d	leath. Do not ent	01 S. Chester Stre	or respiratory	LIIIO	re, Mary	Tand 2123 Approximate
shock, or heart failure. List only o mmediate Cause (Final	-			or respiratory	arrost,		Interval Between Onset and Death
disease or condition	a. (gustroint	estral	he morrhage				
	Due to (or as a con	sequence of):	ageal varices	)			
Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	b. Due to (or as a con	sequence of):	agent various				
cause. Enter Underlying Cause (Disease or injury that initiated events	c. Cwhosis  Due to (or as a con	of M	e liver				
resulting in death) Last	Due to (or as a con	sequence of):					
	d						
E EEMAL S.	d						
	d	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delin	very Day Year
23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	Fetal death 3 [ of death 5 [	Other (specify)			Month use contribute to	Day Year the cause of death?
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	Fetal death 3 [ of death 5 [	Other (specify)	1[	Yes 2	Month use contribute to	Day Year the cause of death?
23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	Fetal death 3 [ of death 5 [	Other (specify)	24a. Wi au	Yes 2  as an topsy rformed?	Month use contribute to	the cause of death?  bably 4 Unknownsperior availation of cause of
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  art II. Other significant conditions co	1 ☐Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	Fetal death 3 [ of death 5 [	Other (specify)	24a. Wi au pe 1 X-Yes	Yes 2 as an topsy formed?	Month use contribute to	Day Year the cause of death? bbably 4 Unknow
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23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 F 4 Pregnant at time of the second s	Fetal death 3 of death 5 cresulting in the u	Other (specify)  nderlying cause given in Part I.  26. Place of Dea of Source of Dea of Source of Dea of Source of Dea of Source of Dea of Source of Dea of Source of Dea of Source of Dea of Source of Dea of Source of Dea	24a. Whau pe 1 🔀 Yes	Yes 2 as an topsy formed? 2 No	Month  use contribute to  a No 3 pro  24b. Were aut prior to c death? 1 2 yes  6 Other (Spec	the cause of death?  babby 4 Unknown  copsy findings availation of cause of
23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	resulting in the u	26. Place of Dea  at 3 DOA Other: 4 Nursing H  28c. Injury at Work?  M 1 Yes 2 No	24a. Wingu pe 1 124 Yes atth (Check onlinome 5   Re 28d. Describ	Yes 2 as an topsy formed? 2 No No No No No No No No No No No No No	Month use contribute to  24b. Were aut prior to c death? 102 Yes  6 Other (Specing occurred)	the cause of death?  babby 4 Unkno  copsy findings availa completion of cause of  2 No  ify)
23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1   Inpatient 2   Regular   1   Inpatient 2   1   Inpatient 2   28a. Date of Injury (Month, Day Year	resulting in the u  ZER/Outpatier  2 XER/Outpatier  2 Bb. Time o Injury	26. Place of Dea  at 3 DOA Other: 4 Nursing H  28c. Injury at Work?  M 1 Yes 2 No	24a. Whau pe 104 Yes only ome 5 □ Re 28d. Describ	Yes 2 as an topsy formed? 2 No No No No No No No No No No No No No	Month  use contribute to  24b. Were aut prior to c death? 102 Yes  6 Other (Speciary occurred	the cause of death?  babby 4 Unknown  copsy findings availation of cause of
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25. Was case referred to medical examiner?  1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide 1 Certifying Phy (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year 28b. Place of Injury (On the basis of exam and manner stated.	resulting in the u  2 XER/Outpatier  2 Bb. Time of Injury  At home, farm, strecify)  knowledge, death innation and/or in	26. Place of Dea  26. Place of Dea  27. Place of Dea  28. Injury at Work?  M 1 Yes 2 No  29. Veet, factory, office  29. License number  O.C.M.E.	24a. Wing au pe 10 Yes with (Check only ome 5   Re 28d. Describ	Yes 2 as an topsy formed? 2 No. y one) sidence e how inju (Street all own, State e cause(se, date an	Month  use contribute to  24b. Were aut prior to c death?  102 Yes  6 Other (Speciary occurred	the cause of death?  bably 4 Unknow  copsy findings availal completion of cause of  2 No  ify)  ral Route Number,  stated.  to the cause(s)
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State Registrar

( _		1 _ For	State of M	laryland / [		rtment of I	Health and I			200	1. 1000
G		Registrar  1. Decedent's Name (First, Middle	n (act)	···	Cert	ilicale of	Dealii	2. Date of De	Reg. N	0. C U U	3. Time of Death
Physic	ian	Harold Vernon						Month May 19	D	2004 Yea	
/Medi Exami		4a. Facility Name (If not institution		•)		4b. City. Town.	or Location of Death			c. County of De	
CXAIIII	IIĆI	Franklin Square				Rose			1		e County
Funeral	Г	5. Social Security Number	6. Sex 7. A	ge (In yrs. last bir	rthday)_	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	th Von	9. 6	Birthplace (State or Foreign
Director		212-48-0365	1 <b>⊠</b> M 2□F	54	Yrs.	Month's Days	Hours Min.	8. Date of Bir (Month, Da 03-20-1	1950	Ma:	ryland
yland		10a. State 10b. County		10c. City, Tow	m or Loc	ation					10d. Inside City Limit
a-fsl	ctor	MD NA		Ва	alti:	more					1 XYes 2 □ N
ith the or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What	Country?
ath wi	rai	1017 E. Preston	Street				1213			SA	
er dez	nue	11. Marital Status	12. Was Decedent Armed Forces	?	13. W	as Decedent of I Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No Dican, etc.)	)-	14. Race - Ar Black, W	merican Indian, hite, etc.
036 urs afte	by F	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes Give		11	□Yes 2XNo	Specify:			Specify:	lack
5-06 2 hours	ted	15. Decedent	t's Education	16a.	. Decede	nt's Usual Occup	pation	, .	16b.	Kind of Busine	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the World Examiner must be notified at angues.	Completed	(Specify only highes	College (1-4or	5+) H			during most of word d) Provider	KING	С	ounseli	.ng
d 2 filled Hygi other	CO	17. Father's Name (First, Middle, I	Last)			our cure	18. Mother's Nam	ne (First, Middle,			0
rlan uld be Aental rkad o	To Be	William Henry	Moody					L. And			
ary		19a. Informant's Name/Relationsh	hip (Type, Print)	19b			and Number or Ru				
and 2 auth a saith a ar tre		Kenyetta D. Moo	ody/ Daughte	r	3524	Parkla	wn Avenue	Baltim	ore	, MD 21	213
Saltimore, permit. Pages 1 ar Department of Hea mportant: If item: my injury or otha nace.		20a. Method of Disposition 1   ■ Burial 2 □ Cremation	3 □Removal from State	cemeter	ry, crema	tion (Name of atory or other pla	ce)	Date	20c. l	_ocation - City	or Town, State
Pag Pag ment ant: I		`4 □Donation 5 □ Other (Sp	pecify)	Mt. Zi	on C	Cemetery	5-26-	04	Ва	ltimore	, MD
Salt ermit epart ny in		21. Signature of Funeral Service I	Licensee 1/	1_		Name and Addre					
m 40 = 4 0		My money	V/1//MC		wyı	ie rune	ral Home	638 N. i	Ci In	nor St	Balto, MD
		23a Part I Enter the disease or								dor bt.	
_			complications that cause only one cause on each	ed the death. Do i						nor bt.	Approximate Interval Between
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Physician /Medical Examiner	-	Immediate Cause (Final	Atheros		not enter	the mode of dyi	ng, such as cardiac			ior be.	Approximate Interval Between
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		1. Decedent's Name (First, Middle, La.	st)		Cert	ilicate of	Deam	2.	Date of Deat	eg. No2 ()	<u>U 4</u>	3. Time of Death
Physic		Christopher S	hawn Nus	sle					Month Say 22,	Dav	Year	7:05 P
/Med Exami		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	r Location of		Ray ZZ	4c. County	of Death	7:05 F
		Stella Maris Hosp	oice			Timoniu	m			Balt	imore	<u>)</u>
Funeral		5. Social Security Number 6. S	ex 7.Ag M∑M2□F	e (In yrs. last b	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreig
Director		213-06-2891 Usual Residence of Decedent	n	35	113.			M	IAY 9,	1969	Vorth	Carolina
yland how		10a. State 10b. County		10c. City, To	wn or Loca	ıtion					10	0d. Inside City Limits
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with th	Dire	10e. Street and Number	D.	- 3		10f. Zip Code				Og. Citizen of V	hat Coun	try?
IN CILISTONIOS  (Iled within 72 hours after death with the Marylend (Ikygiene.  uther then "netural", or Items 23a or 28e-f show sht, the Medical Evaninat must be rediffed at	Completed by Funeral Director	505 F Bowleys Qu	12. Was Decedent		12 14/	21220	lianania Daini	-2 (0it		JSA		
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ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1[	Yes 2∏ No	Specify:			Specify		White
72 h	etec	15. Decedent's Ed (Specify only highest gra		16	a. Decede (Give ki	nt's Usual Occup nd of work done NOT use retired	ation during most o	of working		16b. Kind of Bu	siness/Ind	lustry
A I A I D-UUSO ad within 72 hours af gjene. er then "netural", or the Medical Eram	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+) C	iite. Do Sarper		1)			Self Er	നി വ	ha
Hygi Other	e C	10 17. Father's Name (First, Middle, Last)					18. Mother's	s Name (Fi		faiden Sumam		
Maryland vd 2 should be file lith and Mental Hy 27 Is marked oth treumatic event	To Be	William H. Nussl	e				Belin	da Ka	ye Dew	eese	,	
2 short and he ma		19a. Informant's Name/Relationship (7					and Number	or Rural Ro	oute Number,		State, Zip	Code) 21084
and and mast mast		Belinda K. Matthe	w/Mother			. Jarre				arretts		
iges 1 or of		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State			ion (Name of tory or other place		Date		Oc. Location -	•	
paritimore, Intervient ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23s or 28e-1 show any injury or other treumatic event, the Medical Examinar must be invitited at ance.		*4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Metro		atory I				altimor	e, M	D
Dermi Depa Impo any ii		Thomas Greg	me -		Cr	lame and Addre emation 9 Frede	Socie	ty of	MD, I	nc. more, N	<b>m</b> 0	1228
Provided and American Street of Policy (Medical Examiner of Ponting-Iransit of Ponting-Ir	cai Examiner	23a. Part. Enter the disease, or comy shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACQUIRE  Due to (or as a b. Due to (or as a c.		<b>NE DE</b> of):	FICIENC						Approximate Interval Between Onset and Death
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	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2□ER/O		3C DOA Othe			eck only one			(Control moviments)
	F	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y. 28b.	Time of Injury	28c. Injun Work	at	28d.	5 Resident	v injury occurre		HOSPICE
itel or Attending rs after death. el Director: Afte led in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	iry - At home, fa :. (Specify)	arm, street	, factory, office		28f. L	ocation (Stre City or Town,	et and Numbe State)	or Rural i	Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edicai		rsician: To the best of iner: On the basis of and manner state	of my knowledg examination ar ted.	je, death o nd/or inves			place, and o occurred at	due to the cau the time, dat	ise(s) and man e and place, ar	ner as stai id due to t	ted. he cause(s)
To To	Σ	29b. Signature and title of certifier	APRIL D			29c. License	number		290	d. Date signed	Month, D	ay, Year)
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DHMH 17 Rev 1/2001

7:05 p.m.

MAY 22, 2004

CHRISTOPHER NUSSLE

DHMH 17 Rev 1/2001

Registrar

MAY 2 5 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 0 0 4 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 21, 2004 **Physician** Kathryn G. Nunn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 322 W. Lorraine Avenue Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 30, 1915 South Carolina **Funeral** Months Days 250-30-4106 88 Hours 1 □ M 24 □ F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or than "natural", or Items 23a or 28e-f show 10d. Inside City Limits Maryland N/A Baltimore 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 322 W. Lorraine Avenue 21211 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a any injury or other treumatic event, the Medical Exercites 2006. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes X X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Mt. Vernon Mills 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Claude Byrd Blanche Rogers 19a. Informant's Name/Relationship (Type, Print)
Peggy Marshall Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3850 Conewago Road Dover, Pennsylvania 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 5/24/2004 Woodlawn, Maryland 4 Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licensee <sup>22</sup> Blurgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myo CARDIAL INFARCTION **/Medical** Due to (or as a consequence of). Examiner IABE 2040013 Sequentially list conditions, if any leading to minadate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 Due to (or as a consequence of) Examiner burial-transit certificate be exec Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as the l attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 4☐ Pregnant at time of death signed by the aid 1 □ Yes 2 💌 o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ ¶o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 700 24a Was an has autopsy 1 Yes 2 🗷 I or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 XVo 은 filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide To the Hospital within 24 hours a To the Funerel E 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4076 1/1000 0.1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3100 Wyman Park Drive Baltimore, Maryland Gary Noronha, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 2 5 2004

			1 - For State Registrar	State of Ma	ryland / Depa Cea	artment of H			giene Reg. No. 20	NL	16613
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	/Medic Examir		Henry John N 4a. Facility Name (If not institution, gr	ieberding		4b. City, Town, or	r Location of Dea		4c. County		145H
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	Director		216-07-4334	1 XM 2□ F	Yrs.	Months Days	Hours Min	. (Month, Da	y, Year)	Country)	(State or Foreign
			Usual Residence of Decedent				l	July 23	1914	Maryla	and
	ylan how		10a. State 10b. County		10c. City, Town or Lo	cation				10d. i	Inside City Limits
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	r 28i	irec	10e. Street and Number	.more	1111101	10f. Zip Code			10g. Citizen of V	What Country?	
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	within 72 hours after death with the Maryland piene. r than "natural", or Itams 23a or 28a-f ahow Ita Nedical Examinat must be notified at	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent 8	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (	Specify Yes or No-		e - American I	ndian,
ယ	or Ita	Ē	1 Never Married 2 Married	Armed Forces? 1 🗀 Yes 2 💢 N	0	f Yes, specify Cuba		rto Rican, etc.)	Blac	k, White, etc.	
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<u>a</u>		To E	Frank Nieberdin	ø			Anna		Fronafo	0.1	
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Baltimore,	os 1 and 2 of Health itam 27 I		20a. Method of Disposition	ng	20b. Place of Dispo	sition (Name of		Date Date	20c. Location -		
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Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		Ectopic pregnancy			23d. Date	e of delivery	
m	0 0 2	sicie	in the past 12 months? 1 🗆 Yes 2 🗆 No	4☐Pregnant at t		Other (specify)			Mon	nth Day	Year
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	requires that the	ру Р	Part II. Other significant conditions	contributing to death bu	t not resulting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use contri	ibute to the ca	use of death?
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Vital	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·		_				☐ Yes 2 🗚	No
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	To To Con	_	29b. Signature and title of certifier	mall.		250. LIGHTSB	umbel	2	9d. Date signed	57	
ř			- January	MICHEA	IN-0	D 414	410	۲	May 2	17,20	004.
	10		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, I	Print)			1		
			JOGINDE P. MEH		601 OSLE	R DRIVE	TOWSON	MARYLE	AND 218	1714	
	Sta		31. Date filed (Month, Day, Year)	32. Registra							
	Registr	ar	MAY 2 5 2004	penera	B A	souls					

			1 - For State of Maryland / De C	partment of Health and Nertificate of Death		iene 2004	16614
	Physici	an.	Decedent's Name (First, Middle, Last)		2. Date of Dear	Day Your	3. Time of Death
	/Medic		John M. Power, III		May 19	, 2004 Yeer	1:38 A <sup>M</sup>
A.	Examir	er	4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deetl	1
		ш	816 Selby Heights Drive	Edgewater		Anne Arur	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	(y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Col	nplece (Stete or Foreign untry)
	Director		577-46-1670 68 Yrs.  Usual Residence of Decedent		09–12–	1935   Wash	nington,DC
	/land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mar P-f-et	ģ	Maryland Anne Arundel Ed	gewater			1 □ Yes 2∑ No
	h the	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	intry?
	23a c	atD	816 Selby Heights Drive	21037		USA	
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
9	or it		1 Never Married 2 Married 1 Tes 2 Mo	1 ☐ Yes 200 No Specify:	nican, etc.)	Black, White	, etc. nite
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Maryland 21215-0036	2 should be and Mental is marked raumatic ev	-		iling Address (Street and Number or Rus			n Codel
ž	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic			6 Selby Heights Dr.			
ře,	f Hei		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location - City or T	own, Stete
E	Page nent c nt: If ry or			rematory 5-19	-04	Edgewater,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health s important: If item 27 is any injury or other tra			22. Name and Address of Facility Geo		Zalas Funor	nal Lomo
m	88 5 8		illulo dal-	2973 Solomons Islan	nd Road	rdrewater	Md 21037
h			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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1	/Medical		resulting in death)  Due to (or as a consequence of):	Cunea Onal Cavely			
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687	tificate ig phys as the	edical	d				
×	eath certifications attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Date of delike	intill .
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٥.	The law requires that the death certific te has been signed by the attending p bage 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
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000	aw requise been 2 should	Completed			24a. Was an	24b. Were auto	psy findings available
Ě	The law ate has page 2 a	E			autopsy perform	prior to co	mpletion of cause of
ta	ysician: Th	Be C	25. Was case referred to medical examiner?	26. Place of Death			2 No
<u> </u>	W 17	To.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor		nce 6 Other (Specif	y)
0	ding Phy h. After thi tuneral o	::	27. Manny Death 1 Natural 5 Pending (Month, Day Yeer) Injury (Month, Day Yeer)		28d. Lescribe hov		
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1000	l or Attenc after death Director: I in by the	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	il Route Number,
	spital or Atten ours after deat ieral Director: filled in by the		20.0.45	<u> </u>			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medicai	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or in an anner stated.	ith occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as s te and place, and due to	tated. the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier 7	29c. License number	29	d. Date signed (Month,	Day, Yearl
)	->-0/		Cuitis Harry	153306		- hal	
	15	1	30. Name and address of person who completed cause of death (Item 23a) (Type	. Print)		1/11/02	
	10		Curtis Harris, IND 888 Best 59	Print) te Rd Ste 211 h	Funapul	15 MD 7.1	1401
5	Stat	e	31. Date filed (Month, Day, Year) MAY 2 5 2004  32. Registrar's Signature	1	101		
	Registra	ar	MINI Z D ZUU4	sports			

			1 - For State Registrar	State of Maryla	-			ealth a Death		F	Reg. No.	2004	16615
	Physici	an	Decedent's Name (First, Middle, Last)     WILBUR LOUIS	PICHARD						2. Date of Dea Month May	Day	Year 2004	3. Time of Death 7:35 a
	/Medic		4a. Facility Name (If not institution, give st	reet and number)		4b. City	, Town, or	Location of	Death	Мау	<del></del>	county of Dea	
	Examin	er	Brooke Grove Nursi			5	andy	Spri	ng		i	Montgo	
	Funeral		Social Security Number     6. Sex		s. last birthday)	If Unde	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day	v, Yə <i>ar)</i>	9. Bi	irthplace (State or Foreign Country)
	Director			M 2□F 77	Yrs.				i	Jan 20,	192	7   Pe	ennsylvania
	and w.		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation							10d. Inside City Limits
	Maryl f ehc	tor	MD Montgome	ry B	ırtonsv	ille							1 Tyes 2 No
	h the	lrec	10e. Street and Number			10f. Zi	p Code				10g. Citize	en of What C	Country?
	hours after deeth with the Maryland tural', or Items 23a or 28a-f ehow al Examiner must be notified at	by Funeral Director	14817 Perrywood Dr	ive			20866					S.A.	
	tems	unei	11. Wanta Status	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Dece If Yes, spe	edent of H ecify Cuba	ispanic Orig in, Mexican,	in? (Spec Puerto F	cify Yes or No- lican, etc.)	.   14	4. Race - Am Black, Wh	nericen Indian, nite, etc.
36	rs afte	y F	1 ☐ Never Married 2 ☑ Marned 3 ☐ Widowed 4 ☐ Divorced	XXYes 2 □ No If Yes, Give Year or Dates: WW:	II	1 🗆 Yes	2∏No XX	Specify:			5	Specify: W	White
21215-0036	be filed within 72 hours after deeth with the Marylan hal Hygiene. Id other than "natural", or Items 23s or 28s-f show event, the Medical Examiner must be notified at		15. Decedent's Educ		16a. Dece	dent's Usi	ial Occup	ation	of modern			d of Busines	,
215	within 72 ene. than "nai	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) 4 Years	life.	DO NOT	ise retired			9	-	t. of	Navy ernment
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pu	be fill d off	Be	17. Father's Name (First, Middle, Last)  Louis Pichard							e Covan		umame)	
Maryland	should be and Mental is marked of aumatic even	2	19a, Informant's Name/Relationship (Typ	e Print)	19b Mail	ina Addres	s (Street			Route Number		Town, State,	Zip Code)
Ma			La Vere Pichard /	spouse									ryland 20866
re,	s 1 and if Health Item 27 other tr		20a. Method of Disposition		. Place of Disp cemetery, cre	osition (Na	me of other plac	:e)	D	ate	20c. Loc	ation - City o	or Town, State
E O	Pages nent of I int: if Its iry or o		1 ☐ Burial 2 ② ← mation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	West Ar				May :	25, 04	0de:	nton,	Maryland
Baltimore,	permit. Pages 1 Department of H Important: if Ite any Injury or ot once.		21. Signature of Funeral Service License	- / M007	D	onald	lson	ss of Facility Funera t Avei	al Ho	ome, P. Laurel	A. , Ma:	ryland	1 20707
	-		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the de	ath. Do not er	ter the mo	de of dyin	g, such as o	cardiac o	r respiratory ai	rest,		Approximate Interval Between Onset and Death
,092	Physician /Medical Examiner	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	Avtevequence of):	y I	eas e	Hiei e	ency				great than 2 y as
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medic	in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 f death 5	□Ectopic □ Other (s	specify)					3d. Date of d Month	Day Year
	luires than signed and the de	by	Part II. Other significant conditions con	tributing to death but not i	esulting in the	underlying	cause giv	en in Part I.			obacco us Yes 2□		to the cause of death?  Probably 4 Unknown
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of Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?						of Death	Check on	ne	- D-	
of \	Physi this c	70	1 ☐ Yes 2 💆 No	ospital: 1 ☐ Inpatient 2 28a. Date of Injury	☐ ER/Outpatie		OA Oth	4 A Nut		ne 5 Resident			pecify)
ion	nding P ath. r: After e funera	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yeer,	Injury	М	Wor	k? Yes 2□N	-	.54. 56561156		00001100	
Division	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe		treet, lacto	ry, office		2	281. Location ( City or To	Street and wn, State)	Number or i	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, dea ination and/or i	ith occurre	d at the tir	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) a date and	and manner place, and d	as stated. ue to the cause(s)
	To th Within To th sompl	Me	29b. Signature and title of certifier			1		e number					nth, Dey, Year)
	V	1	Dewett Won	you M)		J	470	582			May	13, 2	-004
	300		30. Name and address of person who co	mpleted cause of death (I	tom 23a) (Type	Print)	ind, i	20832	<b>-</b>	Benn	e#	Morri	lun
	Sta Regist	ate rar	31. Date liled (Month, Day, Year) MAY 2, 5, 2004	32. Registrar's Signal	gnature	low	W						

				1 - For State Registrar	State of	Marylan		artment rtificate					Reg. No.	2004	. 0 0 1 0
		Dhuniai		1. Decedent's Name (First, Middle, Las								2. Date of De Month	Day	Year	3. Time of Death
		Physici /Medic		CATHERINE L.	PALME				F	1	-4.0	Wax	20	County of Death	D:168
	7	Examin	er	4a. Fecility Name (If not institution, give BROADMEADE	street and num	nber)		, ,		Location of				ALTIMO	RE
		Funeral		Social Security Number     6. Security Number		7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir			olece (State or Foreign
		Director		217-14-3931	□ M 273 F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month, Da 03/28	7191	4 MÄR	YLAND
		and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						1	0d. Inside City Limits
		Maryl febo	ট্	MD BALTIMO	RE		COCKE	YSVI	LLE						1 ☐ Yes 2 No
		th the or 28s	lrec	10e. Street and Number				10f. Zip		_			•	en of What Coul	ntry?
2		death with the Maryland ims 23e or 28s-f ehow if is ust be neithed at	Funeral Director	13801 YORK RD					1030				USA	4. Race - Americ	Indian
A		ltems Items	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For		J.S. 13.	Was Deced If Yes, spec	lent of Hi of Cuba	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	)-	Black, White,	
2.	036	urs aff		3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes If Yes, Giv Year or Da	e ates:		1 ☐ Yes 2	No	Specify:	•		S	Specify: WHI	TE
	21215-0036	within 72 hours after ene. then "natural", or Ite he Moulcal Exemine	Completed by	15. Decedent's Ec (Specify only highest gra	lucation de completed)		(Give	dent's Usua kind of wor	k done a	lu <i>ring</i> mos	st of work	ing	16b. Kind	d of Business/In	dustry
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		Hygie Hygie other	မ Co	17. Father's Name (First, Middle, Last)			1			18. Moth	er's Nam	e (First, Middle	, Maiden S	Sumame)	
	ılan	Aental Aental rked tlc ev	To Be	JAMES A. LATAN	1E							ABNEY			
	Maryland	2 sho and to ie ma	i i	19a. Informant's Name/Relationship (										Town, State, Zip $21037$ .	
		1 and Health em 27 ther to		DOUGLAS PALMER ( 20a. Method of Disposition	(2011)	20b. F	Place of Dispo	osition (Nan	ne of	1		Date		ation - City or To	
	no	ages ant of I t: If It y or o		1 Burial 2 Cremation 3  4 Donation 5 Other (Specific	Removal from S	State GR	cemetery, crei REEN M	matory or or IOUNT	ther place CR	e) EMAT	ORY	05/24/	2004	BALTO	. City,MD
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If Item 27 is marked other then "natural", or Items 23s or 28s-1 show with rightry or other traumatic event, the Medical Examinet: sail to notified at ADDS.		21. Signature of Funeral Service Licer			22	2. Name an	d Addres	s of Facili	ty	0.00	NC C	0	
	Ä	Depa Impo eny ir		William &	du I									°. 21111	
_	變			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the deat ach line.	th. Do not ent	ter the mod-	e of dying	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 6	nges	tive	Ha	ary	- t	21	1020			
		Examiner			Dueto	or as a consec	TO 1 ()	Her	ort	- ]	)/5	1041	,		
		D 5	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	Due to (	or as a consec	quence of):			-					
(		and -trans	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c	or as a consec	nuence of):								
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3	687	ificate g phys as the			d		#3								250
-	Вох	th cert tendin r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregnirth 2 Feta		⊒Ectopic pr	egnancy				23	3d. Date of deliver	ery Day Year
E	O. E	that the death ed by the atte detached for	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of o	death 5	Other (sp	ecify)					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	9.		/ Ph	Part II. Other significant conditions of	contributing to de	eath but not res	sulting in the u	ınderlying c	ause give	n in Part	l.	23e. Did	tobacco us	e contribute to t	he cause of death?
-	rds	quires in sign uld be	ed by	Atrial	+16,	rilla	tion					1 🗆	Yes 2 🖾	No 3□Prot	oably 4 Unknown
2	Records	law requir as been s 2 should	Completed									24a. Was	psy	prior to co	opsy findings available impletion of cause of
5		<i>(a) □L</i>	Com									perfe 1 Yes	2 PNo	death? 1 ☐ Yes	2 □ No
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2	ō	Phy: this	To	1 ☐ Yes 2 ☑ No  27. Manner of Death	1   1	npatient 2 of Injury th, Day Year)	28b. Time o		8c. Injury Work	4 12 14	ursing Ho	28d. Describe		Other (Special occurred	y)
0	ion	Attending r death. sctor: After by the fune	atio	1 Matural 5 Pending 2 Accident investigation	n	n, Day Year)	Injury	М		Yes 2	No				
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		To the Hospital or Ai within 24 hours after of To the Euneral Dirac completely filled in by		29a. Certifier 1 Certifying Ph	nysician: To the	best of my kn	owledge, deat	th occurred	at the tim	ne, date ai	nd place.	and due to the	cause(s) a	and manner as s	stated.
		Hos Hos	Medical	(Check only 2 Medical Examone)	niner: On the ba	asis of examina ner stated.	ation and/or in	nvestigation	, in my o <sub>l</sub>	oinion, dea	ath occur	red at the time,	date and p	place, and due t	o the cause(s)
_	1	To the complex	Me	29b. Signat re and title of certifier	1		110	290	. License	number	-0	2	29d. Date	signed (Month,	Day, Year)
•		ſ		Frankard	- A	trip	they the	20_	D	500	37	1		120	12004
		0		30. Name and address of person who	completed caus	e of death (Ite	m 23 / (Type,	Print)	V	ORK	R	D cor	XX	15/11/1	F.MD 30
		Sta	ate	31. Date filed (Month, Day, Year) (AY 2 5 2004	32. R	egistrar's Sign	audo	Long	11	1 1		1,000	1	0010	
		Regist	rar	MTAY Z 5 ZUU4	To Tale	/	- /"		-						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per Dr. FH G832 Gertificate of Death Reg. No. 2004 AMEND TTEM #8.10&f&11 Decedent's Name (First, Middle, Last) 2. Date of Deeth BELL. PERRY Month Year **Physician** 10:30am Perry 05 22-04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Franklin Square Rosedale If Under 24 Hrs. 8. Hospital Center ltimore If Under 1 Year 8. Date of Birtt8-06-1925Birthplace (State or Foreign (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours Min. 1 □ M 2√2 F Yrs. 231-30-0527 N.C Director Usuel Residence of Decedent filed within 72 hours efter death with the Merylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 X Yes 2 ☐ No DUNDALK Directo Md. NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 101 Centre Place Apt. 202 21224 USA 21222 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or i Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed within Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Men in Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event, the Men Injury or other traumatic event even Other People Homes Domestic 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kerry, Berta Solomom Wiggins ZumaAvent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6428 Bushey Street, Baltimore, Md. 21224 Willie Thomas Perry Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Vet. Cem. 5-28-04 Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. March F.H. East 1101 E. North Ave. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Colon Cancer Metastatic Examiner Due to (or as e consequence of) Physician/Medical Examiner ettending physician end I for use es the buriel-transit To the Hospital or Attanding Physician: The lew requires thet the deeth certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 □ Probably 4 □ Unknown failure Dia betes Division of Vital Records. δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? been si Completed certificete has b director, pege 2 s 1 \_ Yas 2€ No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: edical Certification: To 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Deeth I Director: After the d in by the funeral 5 Pending 1 MNatural 1 TYes 2 TNo investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier apinem RES 00000 mD 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Sud hakar

31. Date filed (Month, Day, Year) MAY 2 4 2004 9000

32. Registrer's Signature

Tapineni

Franklin Square Drive Ba Himore, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RANDALL Year **Physician** 6 EDPGE 07:15 AM MAY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 704 Stillwater Road Gibson Island Anne Arundel Months Days Hours Min. 8. Date of Birth (Month Day, Year) Aug 5, 1950 5. Social Security Number 6 SAY 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XXM 2□F 216-46-4995 Maryland Director Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Frederick Maryland Rocky Ridge 1 Tyes 2/CXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15011 Motter Station Road 21778 U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use jettined) President/Publisher 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Daily Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Randall Frances Myron William Sr Ann Delaplaine Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a: If item 27 is Mrs. Elizabeth Randall/Wife P.O. Box 58, Rocky Ridge, Maryland 21778-0058 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. Mt Olivet Cemetery May 15, 2004 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 Fast Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service Licenses Keeney & Basford P.A. Fune M00706 106 Fast Church Street, Fred Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GLIOBLASTOMA MULTIFORME **Physician** 7 MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation death within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel LX Certifying Physician. To the basis of my knowledge, death occurred at the line, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifler Medical 29c. License number 29d. Date signed (Month, Day, Year) 00057802 MAY 13, 2004

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Vital

o

Division

31. Date filed (Month, Day, Year) MAY 2 5 2004

Wells Messersmith Me 1650 Orleans Street CRB 692 Baltimore, Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M	laryland /		artment			and M	lental Hy	giene	$\leq U$	04	16619
			Decedent's Name (First, Middle, Last	t)							2. Date of De	ath			3. Time of Death
	Physici		Michael	F	andol	ph				1	May 1	l4, <sup>D</sup> å	004	Year	1:50A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	)		4b. City, 1	Town, or	Location of	of Death		4c	. County o	f Death	
			Harbor Hospit					tim					N/A		
	Funeral Director		5. Social Security Number 6. S 217-66-4727	9x 7. A. 7 M 2□ F	ge (In yrs. last 47	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Di 8-21-	ay, Year)		9. Birthp Cour MD	
	put		Usual Residence of Decedent  10a, State 10b, County		10c. City, To	own or Lo	cation							1	Od. Inside City Limits
	Aaryla I sho	ō	MD N/A		Balt										1 XYes 2 No
	28e-1	rect	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of W	hat Cour	itry?
	3a or	Funeral Director	2812 Spelman	Rd			21	225					U.S.	Α.	
	ms 2	nera	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Deced	ent of His	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	0-		- Americ	an Indian,
9	72 hours after deeth with the Maryland natural', or Itama 23a or 28e-f ahow disal Examena must be natified at	F	1 XNever Married 2 Married	1 Tes 2 T		1	1 ☐ Yes 2	-		i, Fuello	rican, etc.		Specify:		
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21215-0036	n 72 n 72 edice	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usua kind of wor DO NOT us	k done di	uring mos	t of worki	ing	160. K	and of Bus	iness/ine	dustry
212	d within liene. r than	шо	Elementary/Secondary (0-12)	College (1-4or		pain	ter	/ c	arpe	nte	r	Но	me I	mpr	ovement
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la la	2 short and and less many		19a. Informant's Name/Relationship (								il Route Numb	-			
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nor	eges int of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specific	Removal from State		itery, crer	natory or ot	her place		21_4	2004		sdow	•	MD
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o,	en an		resulting in death) Last	Due to (or a	s a consequen	ce of):									
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9	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcom-	e of pregnancy			-					00 d D	-6 d-15 -	
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	-6			Othe			(Check only				
of	g Phys ter this neral di	1: To	1 ☐ Yes 2 ☑ No  27. Manney of Death	28a. Date of Inj (Month, D		Outpatier		Bc. Injury Work	4 🗀 NU	-	me 5 Res 28d. Describe				/)
ion	를 곧 돌 글	atlor	1 Natural 5 Pending 2 Accident investigation		ay Year)	Injury	М		:? /es 2 🗌	No					
Division	I or Attendi after death. Diractor: A I in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of It	njury - At home atc. (Specify)	, farm, str	eet, factory	, office			28f. Location City or To			r or Rura	l Route Number,
0	urs af arel D arel D		On Continue of the Assistance Div	valais av Tarka bas	h af m (m	<b> </b>				d =1===			<b>.</b>		
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the bes niner: On the basis and manner s	of examination	and/or in	vestigation,	in my op	pinion, dea	ith occurr	ed at the time	date an	d place, an	ner as si	the cause(s)
	To the To the comp	Σ	29b. Signature and little of certifier	71/0	An				number	-0	,				Day, Year)
	2		1 Camarac	Kike	00						/			-	
	.2		30. Name and address of person who Tamara L - Kile		death (Item 23 3001	a) (Type. Sout	Print) h Har	nover	r Stu	reet	Bait	mer	e, n	D.	21225
· ·	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature		Coase	4							
4	Regist	di	MAY 2 5 2004	A SEPARA	- 10	12	yourse	4							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Rudy 19 2004 Thomas Douglas May 11:58 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Sex 1XXXM 2□F 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Jul 18,1946 Birthplace (State or Foreign Country) Funeral Director 062-40-7504 Yrs. 57 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28a-1 show other treumatic event, the Nexical Examinat must be notified at 1 ☐ Yes 2XXNo Directo MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 8207 Grassland Road 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo white þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other then "ns (Specify only highest grade completed) Elementary/Secondary (0-12) U.S. Marines/ College (1-4or 5+) defense Communications/ contractor General Dynamics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Rudy Mildred Pilitowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permil. Pages 1 and 2 st Department of Health and Important: If item 27 Is n eny injury or other treun once. Mrs. Masako E. Rudy / wife 8207 Grassland Road, Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation May 22,2004 Stevensville, MD 21. Signature of meral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** MYOURDIAL NEARCTION disease or condition resulting in death) ONE HOUR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown CHOLESTEROL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No OBESITY 1 ☐ Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ★EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 No death. s after death. investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 24 hours after 16 Funerel Dire bletely filled in b 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) To the within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 35621 6 5/20/2004  $\sqrt{y}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COCHRANE PRIVE ANNAPOLIS, MOZIYA 10MIRAL FREAS MO 180 DAVID GWIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 25 Registrar

			1 - For State Registrar	State of	Marylar		artment rtificate			and M	lental Hy	/gier	2001	166	21
	Physici		Decedent's Name (First, Middle, L Ambrose	T.			Re	wers			2. Date of De Month	eath	Dav Year	3. Time of	Death
	/Medic Examir		4a. Facility Name (If not institution, g		oer)				Location o	f Death	May	22,	, 2004 4c. County of Deal	5:06	АМ
	Exami		Gilchrist Cente				Tow						Baltin		
	Funeral		Social Security Number 6.		Age (In yrs.		If Under	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bi	rth		hplace (State o	r Foreign
L	Director	- 5	213-05-4474 Usual Residence of Decedent	1 M 2 □ F	87	Yrs.	Wichting	Days	riours		May 13	3, 1	1917 M	D.	
	yland 10W		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Ci	ty Limits
	B-fsh	tor	MD. Baltim	ore		Dunda	ılk							1 🗆 Yes	2 <b>X</b> No
	ith the Marylar or 28a-f show	Director	10e. Street and Number				10f. Zip (	Code				10g.	Citizen of What Co	untry?	
	ath w		1972 Searles Roa					1222					USA		
	ltems	Funeral	11. Marital Status	12. Was Decede	as?	.S. 13. \	Was Decede f Yes, speci	ent of His fy Cubar	spanic Orig n, Mexican,	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White		
920	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show he Medical Examinar was be mullibut at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Date			1□Yes 2	🛚 No	Specify:				Specify: Whi	te	
21215-0036	72 hou	ted	15. Decedent's			16a. Deced	lent's Usual	Occupa	tion			16b.	Kind of Business/	ndustry	
218	thin 7 19. "r	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	kind of work OO NOT use	done d retired)	uring most	of worki	ng			,	
2	led w lygier her th		12 Years			I	nspec						ethlehem	Steel	
anc	d be findal hed of	Be	17. Father's Name (First, Middle, Las Frank Rewers	61)							(First, Middle Narczyn				
Maryland	should nd Me mark matic	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	a Address (	Street a					y or Town, State, Z	in Code)	
	alth ar 27 is or trau	l j	Frances Rewers	wife	<b>:</b>						lk, MD.			ір Соаву	
ore,	of He of He fitam r othe	1	20a. Method of Disposition 1 X Burial 2 □ Cremation 3	Damauel from St		Place of Disposemetery, cren	sition (Name	e of ner place	a)	D	ate	20c.	Location - City or	Fown, State	
Ε̈́Ξ	Pag Iment Ient: I		`4 □ Donation 5 □ Other (Spec		St.	Stanisl							ltimore,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show amy injury or other traumatic event, the Medical Examinational porcessions.		21. Signature of Funeral Service Lice	C. Co	mel	Ver 71	nnell 10 So	Address y Fi ller	of Facility ineral s Poi	l HOr int I	me Of D Road, D	Unc	dalk,P.A. dalk,MD.	21222	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that cau y one cause on eac	sed the death	h. De not ente	er the mode	of dying	, such as c	ardiac o	r respiratory a	rrest,	,	Approximate Interval Bety	) veen
	Physician		Immediate Cause (Final disease or condition	· W	1	anon								Onset and D	eath
	/Medical Examiner		resulting in death)	Due to (or	as a conseq									9	-0
		ē	Sequentially list conditions, if any, leading to immediate	b	as a consequ	uence of):					_				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	`											
o	an an	Exa	resulting in death) Last	c Due to (or	as a consequ	uence of);									
8760,	icate be executed physician and s the burial-transit	dicai		d											
9	death certifica attending ph for use as t	/Med	IF FEMALE:	20- 11		_					_			-	
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?		me of pregna n 2 □ Fetal t at time of de	I death 3 🗌	Ectopic pre						23d. Date of deliver Month		ear
o.	that the de ed by the detached	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□Unknow		eath 5	Other (spec	cir <b>y</b> )							
S, P	law requires that the death certific as been signed by the attending p 2 should be detached for use as	by Pr	Part II. Other significant conditions	contributing to deat	h but not rest	ulting in the un	derlying cau	ıse giver	n in Part I.		23e. Did to	obacco	use contribute to	the cause of de	ath?
rds	w require been sig should b						_				1 🗆 🗅	res :	2 No 3□Pro	bably 4 🗀 U	nknown
Record	e law re has bea	Completed									24a. Was		24b. Were aut	opsy findings a	vailable
	The ate h page	Com										rmed? 20 <b>∑</b> 1N	death?	ompletion of ca 2□ No	use of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11				T -		of Death	(Check only o	<u> </u>			
	hys his il dii	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpa		ER/Outpatient			4 🗆 Nurs		e 5 Resid		6 Other (Speci	M) HOS	2100
O	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation		Day Year)	28b. Time of Injury	M	D. Injury a Work?	at es 2.⊡Ne		8d. Describe h	now inj	ury occurred	,	
Division of	or Attanding Patter death. I Diractor: After t	ifica	3 Suicide 6 Could not	be 28e. Place of	Injury - At ho	me, farm, stre			33 2		8f. Location (S	Street a	and Number or Rui	al Route Numb	er.
á	spital or A ours after naral Dirac filled in by	Certification:	4  Homicide determined	building,	etc. (Specify	<i>'</i> )					City or Tow	vn, Sta	te)		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 12 Certifying P	hysician: To the be miner: On the basis and manner	s of examinat	wledge, death ion and/or inv	occurred at estigation, in	the time	e, date and nion, death	place, a	nd due to the o	cause( date ar	s) and manner as and place, and due to	stated. o the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	$\wedge$	1			License					ate signed (Month,		
	1.		M. Anth	my Ki	ley,	no	D	2	520	5		M	Ay 22,	2008	
	10		30. Name and address of person who	completed cause of	1//		Print)	//	-0	0	C	0	Ay 22,	, >/>	4.5
	-212		31. Date filed (Month, Day, Year)	32 Reni	strar's Signat	670	1 /4		tra	l.	۵/، ۱	Z CA	etto m	1 - 10	
	Stat Registra		MAY 9 E 2004	Res a	16	brook	,								

5:06am

Rewers, Ambrose

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 1 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Agnes Physician 40 3am Reaves 22 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner BALTIMORE Randallstown. Hospital Center Northwest 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign NORTH CAROLINA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 2 214-16-5051 may 13, 1922 Director Usuel Residence of Decedent 10d. tnside City Limits deeth with the Marylend 10c. City, Town or Location permit. Peges 1 and 2 should be filled within 72 hours efter deeth with the Maryle Depertment of Heelth and Mantel Hyglene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28e-1 ehow eny Injury or other traumatic event, the Maddeal Examinar must be notified at 1 ☐ Yes 2 → No Randalls town Baltimore MD Director 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 21133 USA Liberty ROGO 9109 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. aitimore, Maryland 21215-0036 Specify: Black À 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be ADDIE WILLIAMS MANNING WILLIAMS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2120 19a. Informant's Name/Relationship (Type, Print) Warren Park Drive Pikesville, mo Elsie Cole 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Deremation 3 Removal from State DRUID RIDGE CEMETERY 5-27-2004 BALTIMORE, MARYLAND Other (Specify) 4 Donation D. HIBNER Name end Address of Facility PHILLIPS FUNERAL HOME, P.A. hice see JONATHAN 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pert/ Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiogenic Shock Examiner Myocardial Infarction. Examiner nding physicien and use es the burial-trensit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wilknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No T MNO TLI Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manne Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? 1 PNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled edicai ( 112 critifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058141 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) MD andalls hwn Court Road 5041 31. Date file MAD Vh. 205 Year 04 32. Registrer's Signature State Registrar

DHMH 16 Rev 6/95

**ORIGINAL** 

04-03495 Tanika Streeter **RJD** 

unpend iten#23a-27 28a-£ PFR MF (832 6/17/0) Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mergth 24, Physician 2004 0220A. M ANIKA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 215 · 13 · 2777 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside Lity Limits 10c. City, Town or Location or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MDBALTIMORE 1 Nes 2 No by Funeral Director 10e, Street and Number 5517 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital-Status Black, White, etc. 1 Never Married 2 ☐ Married filed within 72 hours after ☐ Yes 2 No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No ISLACK 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fift Department of Health and Mental Hy Important: If Item 27 is marked oth any ligitry or other traumatic event ODEs. ENGENE STREETER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a. Informant's Name/Relationship (Type, DOTOMAC St. BACTIMORE, MO 21213 HATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State MEMORIAL PARK \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WAVGHN C. GREENE FWELSE Home 21. Signature of Funeral Service Licensee BAUTIMORE MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Head Injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ▼Yes 2 □ No 28a. Date of Injury (Month, Day) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending **1:00а** м 1 Natural death. unknown investigation 1 Yes 2 No 2 Accident Director: filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 3400 The Alameda, Baltimore, MD street Hospital vithin 24 hours of To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier he 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1706 AV

32. Registrar's Signature

O.C.M.E.

May 24, 2004

111 Penn Street, Baltimore, Maryland 21201

NAME KNOWN TO PHYSICIAM!

	For State Registrar	State of Ma	,	Certificat			,	Reg. No	200	141	6621
	Decedent's Name (First, Middle,	Last)					2. Date of Do Month	eath Da	y Ye		me of Death
an cal	PERLOW SOWE						MAY	21	200 County of D	-	ZUPM
er	4a. Facility Name (If not institution,	11/2	Cicho	4b. Gity	Town, or Loca	tion of Death		40.	CECI		
		S. Sex 7. Age	(In yrs. last bit	thday) If Under		nder 24 Hrs. urs Min.	8. Date of Bi (Month, D	rth I			tate or Foreign
	247-46-5089	13⊠ M 2□ F 7	3	Yrs.	Day's The		Februa	ry 2	6 So	uth Ca	rolina
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location						10d. Ins	ide City Limits
Director	MD Prince	George's	Hya	ttsville	e						]Yes 2 □ No
Dire	10e. Street and Number 5404 Sargent R	oad		10f. Zi	ip Code 20782			10g. Cit	izen of What U.S.		
5	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Dece	edent of Hispan	c Origin? (Spe	ecify Yes or N	0-		American Indi	an,
Funerai	1 Never Married 2 Marrie	Armed Forces? d 1 XYes 2 □ N		If Yes, spe		xican, Puerto	Rican, etc.)		Black, V Specify:	Vhite, etc.	
D D	3 Widowed 4 Divorced	If Yes, Give Year or Dates:				ochy.		101 16		Black	
lete	15. Decedent's (Specify only highest	grade completed)		Give kind of w life. DO NOT a	ual Occupation ork done during use retired)	most of work	ng	16D. K	ind of Busine	ess/industry	
Completed	Elementary/Secondary (0-12) 11th	College (1-4or 5		Upho1st	ery				Priv	vate	
Bec	17. Father's Name (First, Middle, La Perlow Sowell				18. !	Nother's Name		e, Maider eal	Sumame)		
ဥ			101	o. Mailing Addres	es (Street and N				or Town Stat	te Zin Code)	
	19a. Informant's Name/Relationshi  Lena B. Sowe11	_		04 Sarge						20782	
	20a. Method of Disposition			of Disposition (Na ery, crematory or			Date			y or Town, St	ate
	1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specific		1	and Vete	eran's		2004	_			
	21. Signatura of Fune al Service Li	icen e			and Address of Landove						me 785
	6/									110 20	
	232 Part 1 Enter the disease of c	complications that caused	the death. Do						iai y iai	Appro	eximate
	shock, or heart failure. List o	Δ	ne.	not enter the mo					iai y Lai	Appro	eximate al Between t and Death
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DHMH 17 Rev 1/2001

MAY 2 5 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rose Sullivan Amend Item #10b-d jeer fil Wasyland / Department of Health and Mental Hygiene 04 - 3394For A State Registrar AKG Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** ivan hereso May 20. 2004 11:26 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If Under 1 Year | If 6503 1/2 Old Harford Road If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min 1 M 200 F Hours Yrs. MARYL Director UNKNOWN. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10h County or 28a-f show n/a the Medical Examiner must be notified at 1 Yes QNo Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6503 HARFOR 238 d filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Johns Hopkins al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) egister 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked ott Morton BROWN Jennie ္ရ 19a. In ormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Sur DO PY FRAM Malcolm F. othar 20b. Place of Disposition (Name of cometery, crematory or other place Date 20c. Locatin - City or Town, State 20a. Method of Disposition ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sprivice Licensee 31274 8200 x GRETORD ROAD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Winknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No certificate 1 Yes Division of Vital To the Hospital or Attending Physician. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\times$  ther (Specify) At scene 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 2 No death. 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide in 24 hours the Funeral Directory filled in 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Typedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

31. Date filed (Month, Day, Year)

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ORIGINAL

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32. Registrar's Signature

O.C.M.E.

May 20, 2004

111 Penn Street, Baltimore, Maryland 21201

		riease	Type of Pill					_	ne.
		For	State of Ma	-		Health and M	ental Hy	giene 0	11. 10000
		1 - State Registrar		Ce	rtificate of	Death	F	Reg. No.C U	14 16626
		1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	_	3. Time of Death
Physic /Med		Patricia	Ju	dy	Scot	tt	May	23 2	COL GA M
Exami		4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town,	or Location of Death	77.100	4c. County of	of Death
		Moray Hospital			Baltime	oro	,		
Funera			Sex 7. Ag	e (In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h ,	9. Birthplace (State or Foreign
Director		236-56-2004	1□ M 2√√X	54 Yrs.	Months Days	Hours Min.	(Month, Da)	1 50	Country) MD
70		Usual Residence of Decedent							
ylan		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
15-0036 17 thours after death with the Maryland natural; or itema 23a or 28a-f show fedicine mast be notified at	Director	MD NA		Baltimo	re				1 XYes 2 No
n the	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
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ma 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.		Hispanic Origin? (Spe ban, Mexican, Puerto I	cify Yes or No-	14. Race	- American Indian,
	Ē	1 ☐ Never Married 2 ☐ Married	1 TYes 2 X	No			Rican, etc.)	Black	, White, etc.
030 urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify:	Black
C   C   Within 72 hours after one. Ithen "natural; or ite healest Examina	ted	15. Decedent's E	ducation	16a. Dece	edent's Usual Occu	pation		16b. Kind of Bus	siness/Industry
215 Pale 7	ple	(Specify only highest grant Elementary/Secondary (0-12)	a <i>de completed)</i> College (1-4or 5	(Give	e kind of work done DO NOT use retire	during most of working ad)	ng .	Spring	Grove
25 Paragram	Completed by	12th grade	4yrs		Nurse			Hospita	al Center
The string of th	BeC	17. Father's Name (First, Middle, Last				18. Mother's Name	(First, Middle,	Maiden Sumame	ı)
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laryland 21215-0 2 should be filed within 72 ho and Mental Hygiene. Is marked other than "natur aumatic event. It a Madical	-	19a. Informant's Name/Relationship (		19b. Mail	ing Address (Street	t and Number or Rura	Route Numbe	r, City or Town, S	State, Zip Code) 21207
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event. Ite M. Dince.	ĺ	Teadra McMicha	el-Daugh			rook Dr.			
Baltimore, Misser and 2 Department of Health a mportant: if them 27 is any injury or other transons.		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of	LOOK DI.	ate		City or Town, State
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		23a. Part1 Enter the dispase, or con shock or heart failule. List only	one cause on each lir	the death. Do not er	iter the mode of dyl	ing, such as cardiac of	r respiratory ari	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	- 3	2600	ic Lan	(4)			Onset and Death
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OX 68' certificat nding phy	ed								
Box eath cerr attendin for use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnanc			23d. Date	of delivery
d forth	<u>c</u>	in the past 12 pronths?	4 ☐ Pregnant at		□Ectopic pregnand □ Other (specify) _	.у		Mont	h Day Year
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Division of Vital Rec To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to	edical	(Check only 2 Medical Exer	miner: On the basis of and manner sta	examination and/or in	ivestigation, in my	opinion, death occurre	d at the time, d	ate and place, an	id due to the cause(s)
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13)		30. Name and address of person who	10-	eath (Item 23a) (Type.	Print)	$\Omega_1$ $\alpha$	14.		1 7.12
		31. Date filed Month Day Var 14	se berg	Signature	THAT	KT De	Himor	c Mc	1. 21202
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			For State Registrar		State	of Ma	ıryland	/ Depa	artment tificate	of H of L	ealth and Death	d Me		jiene 2 leg. No.	004	16	627
			1. Decedent's Name (First, M	Aiddle, Las	st)							2	2. Date of Dea Month	ith Day	Yeer	3. Time o	f Death
	Physicia		Floren	ce	Μ.	Scl	huck						May 22			2:10	АМ
	/Medic Examin		4a. Facility Name (If not insti	tution, give	street and r	number)			4b. City, To	own, or	Location of D	eath		4c. Co	unty of Deat	h	
		ш	Oak Crest Ca	re Ce	enter				Park						timor		
-	Funeral		5. Social Security Number	6. S	ex □ M 2 <b>⊠</b> F		(In yrs. las		If Under 1 Months	Year Days		/lin.	Date of Birtl (Month, Day	Year)	9. Birt	hplace (State untry)	or Foreign
8	Director		215-34-9929			9	4	Yrs.					11/23/1	909	D	<u>E</u>	
;	and *		Usuel Residence of Deceder 10a. State 10b. Co				10c. City,	Town or Lo	cation							10d. Inside C	City Limits
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Ð	28a-	Director	MD Ba	altim	ore		Par	kvill	10f. Zip C	ode				10g. Citizen	of What Co	untry?	
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N	ours after death with the Maryland rat', or Itams 23a or 28a-f show Examiter roust be notified at	Funeral	11. Marital Status		12. Was De		ver in U.S.	13.			spanic Origin? n, Mexican, Po	? (Speci	ify Yes or No-		Race - Ame	rican Indian,	
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	be fi	Be	John Whee								Anna		Gesell	Maidell 301	manne)		
ત કૅ	should nd Men marke umatic	<sup>2</sup>	19a. Informant's Name/Rela		Type Print)	-		19h Mailir	a Address (	Street	and Number o			r City or To	um State 2	in Code)	
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(e)	1 an Heal tam 2		Anne Gaver 20a. Method of Disposition	∕ oaug	nter		20b. Pla	ce of Dispo	sition (Name	of	Creame	Da	te , w	20c. Locati	ion - City or	Town, State	101
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Saltimore	artme ortan injur.		21. Signature of Fundral 5			- 5	11223		. Name and	<u>.</u>	- 1					Home,	
Ba	Dep Imp any		Merky &	Hd.		6. Co	ster	1	050 Yo	ork	Road		son, M			204	
			23a. Part1. En er the diseas shock, or heart failure.	se, or com List only	plications that	t caused	the death.	Do not ent	er the mode	of dying	g, such as car	diac or	respiratory ar	rest,		Approxima Interval Be	tween
10	Pnysician		Immediate Cause (Final disease or condition			Ca	rdi	ome	AD DE	tt	ny					Onset and	Death
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	Examiner	L	Sequentially list conditions,		b	/					,						
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7.	be executed ician and buriat-transi	xan	that initiated events resulting in death) Last	- 1	c. Due	to (or as a	a conseque	nce of):									
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×	ath certiff attending for use as	N/W	IF FEMALE: 23b. Was decedent pregnat	nt	23c. If yes,				ne					23d	Date of del	ivery	
X m	death e atte d for	cia	in the past 12 months? 1 □ Yes 2 □ No		4□Pre	gnant at	2 □Fetal d time of dea		Ectopic pred Other (spec						Month	Day	Year
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_	tending Physicien: The law leath. tor: After this certificate has the funeral director, page 2	ion:		ending		te of Injur onth, Day	Year)	28b. Time o Injury	M 280	c. Injury Work	/at ⟨? Yes 2 □No	28	d. Describe h	ow injury of	ccurred		
Sign	uttandi death. ctor: A y the fu	cat	3 ☐ Suicide 6 ☐ C	ivestigation ould not b	000 010	ace of Inju	Inv. At hom	a farm et	reet, factory,		165 2 140	28	of Location (5	Street and N	umber or Ri	ıral Route Nur	nber
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_	To tha Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certifica completely filled in by the funeral director.										ne, date and p						- \
	ha Hc in 24 I ha Fu pletely	Medical	(Check only 2 Me	gical Exar		anner sta		on and/or in	vestigation, ii	n my o	oinion, death o	occurred			-		s)
	To t To t	Σ	29b. Signature and title of c	ertifier		1	D		29c.	License	number	7	-	29d. Date si	idned (Mont	h, Day, Year)	)
	./		- /		Y	1				) )	765	27		0	14	107	
	b		30. Name and address of p	rson who	completed ca	ause of de	eath-Hiero 2	23a) (Type,	Print) P.	DT	Inn F	Shi	1	anh	J. U	P M	1)
	2		31. Date filerii/Moreth-Day-	Year -	1/2	Registra	ar's Signatu	Ire/	uvu	<u>u</u>	V-C 9	100		~ ~		1	
-	Sta Registi		31. Date filed (Alogth 20 a)	2004	C. C.	- dia	2	Ø,	Spark	21							

REPLACEMENT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 09 AM **Physician** Di 2004 nne MARIE MA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 - M 2XXF Mary land 32 Yrs. 219-15-1986 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, it a Modical Examinat misst be rediffical at Yes 2 No Directo Baltimore Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21225 USA 3822 2nd Street Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Plumbing And Elementary/Secondary (0-12) College (1-4or 5+) Counter Sales Electrical Sales permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other: any injury or other traumatic event. It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Patricia Mauerhan William Joseph Huff, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3822 2nd Street, Baltimore, Maryland 21225 <u> Charles Eugene Scott - Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/27/2004 Glen Burnie, Maryland \* 4 ☐ Donation 5 👿 Other (Specify) Glen Haven Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fink Funeral Home, PA 426 Crain Highway S., GlenBurnie, Maryland 21061 Kelly Gregory Fink #M01148 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CardiAc **Physician** MINS /Medical LOBE Due to (or as a consequence of) Examiner DULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. the attending physicien Completed by Physician/Medical page 2 should be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 🗆 No P.O. 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records. BRONCHODINGUMON HI INTERSTITIAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No has 1 Yes 2 🗆 No alato funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1X Yes 2 \( \subseteq No Other: Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			for State	State of Marylan						_	1001	1 ~ ~	
			1 - State Registrar  1. Decedent's Name (First, Middle, Las		Cei	tificate of	Death	1	2. Date of De	Reg. No.	UUL		129
	Physicia	an	FLORENCE SHERN	,					Month	Day	Year	3. Time of	
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location	of Death	likery	40.0	ounty of Deat		Am
	Examin —	er	STELLA MARIS  5. Social Security Number 6. Se	MERCY HOSP		BALT]	MORE	3	8. Date of Bi		N/A	hplace (State or	
	Funeral Director			<sup>^</sup> M 2 <b>⁄ Z</b> F	• • • • • • • • • • • • • • • • • • • •	Months Days	Hours	Min.	(Month, D.	2 <sup>4</sup> / <sub>4</sub>		. I O	
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. And other then "naturel", or items 23e or 28e-f show event, the Medical Examinar must be notified at	J.	10a. State 10b. County	10c. Cit	y, Town or Lo							10d. Inside Cit	•
	the N	Director	MD N/A		BALTI	MOKE 10f. Zip Code				10- Citiza	on of What Co		
	with be or		6411 EASTBOURI	JE AVE		212	224			US		outility?	
	Jeath ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.		Vas Decedent of I	Hispanic Ori	igin? (Spe	cify Yes or No		. Race - Ame	nican Indian.	
	riter or iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	'	Yes, specify Cub	an, Mexicar	n, Puerto	Rican, etc.)		Black, White		
	rel', o	l by	3 Nidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐ Yes 2 No	Specify:			S	pecity: W	HITE	
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	ould be f Mental I arked of	o Be	CASIMIR SOKAL						INA WO				
	s 1 and 2 should be I Health and Mental Item 27 is marked o other treumatic ev	은	19a. Informant's Name/Relationship (7	γρe, Print)	19b. Mailin	g Address (Street	1					Zip Code)	
	nd 2 alth a 27 is r treu		MRS. DIANE BLAN	IK	The same of the sa	- WHITET <i>A</i>						21128	
	os 1 and 2 of Health item 27 i		20a. Method of Disposition	30b. 8	lace of Dispo	tion (Name of I	ce)		ate		ition - City or		
	Page nent c int: If		1	tollioval ilolli Stato	Y CEM			/26/	/04	BALT	IMORE	, MD	
	permit. Pages Department of I Importent: If ite any injury or of once.		21. Signature of Funeral Service Licens	ee P	1 8	ACZOROW	TSK Toili	FUNE	ERAL H	OME	P.A.		
	ತಿರ್ವಹಕಾಗ		(ugene)	- Cath		201 DUN					RE, M	D. 212	22
	7		23a. Part1. Enter the disease, or comp shock, or heart failure. List buy of	lications that caused the deat! ne cause on each line.	n. Wo not ente	or the mode of dyli	ng, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Betw	/een
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	es that the igned by th be detache	by PI	Part II. Other significant conditions co	ntributing to death but not resu	alting in the ur	derlying cause giv	ven in Part I		23e. Did t	obacco use	contribute to	the cause of de	ath?
	E 00 70								1 🗆 '	Yes 2	<b>1</b> 60 3□ Pro	obabiy 4 □Ur	iknown
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	ysicien: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place	of Death	(Check only o				
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	ding P	on:	27. Manner of Death 1-□ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		0	28d. Describe	how injury o	ccurred		
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	= E # 6	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, tarm, stre	et, factory, office		2	City or To		Number or Ru	ral Route Numbe	er,
	Hospitel 4 hours 6 Funerel tely filled		29a. Certifier 1 Certifying Phy	sicien: To the best of my know	wledge, death	occurred at the tir	me, date an	d place, a	and due to the	cause(s) ar	nd manner as	stated.	
	ne Ho ne Fui sletely	edical	(Check only 2 Medicel Exam one)	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, dea	th occurre	ed at the time,	date and pl	ace, and due	to the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	^		29c. Licens	e number			29d. Date s	igned (Month	. Day, Year)	
	.,		DN 11	7 ~		240	854			51	24/2	001	
	4		30. Name and address of person who c	ompleted cause of death (Item	23а) (Туре, І	Print)	^	0				2	
			31. Date filed (Month, Day, Year)	32. Registrar's Signa	1 57.	PAUL	PL	10c	Himor	~ 1	nd.	20217	
	Sta		MAY 2 5 2004	Jz. Hegistral's Signal									
	Registra	ar	1111 7 5 2004	AFL.									

ORIGINAL

			1 - For State Registrar	State of M	arylan	•	artment rtificate			and M	-	giene Reg. No. 2	004	16630
	Physici	an	1. Decedent's Name (First, Middle,								2. Date of De.	ath Day	Year,	3. Time of Death
9	/Medic	al	Melva	Rose			Schu			of Dooth	May	73	2004	11:154
	Examin	er	4a. Facility Name (If not institution, Union Memorial				Balt		Location o	or Death	/		nty of Death	
-	Funeral	-			je (In yrs. I	ast birthday)	If Under	1 Year	If Under		8. Date of Birt	th	9. Birthi	olace (State or Foreign
24	Director		212-26-5760	1□M 2 <b>X</b> F	81	Yrs.	Months	Days	Hours	Min.	July 28	1922	Cou	
	pu a		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation						1	10d. Inside City Limits
	Aaryla I sho	ō	MD. Baltim	oro		Dunda								1 ☐ Yes 2 ☐ No
	28a-	rect	10e. Street and Number	ore		Durida	10f. Zip	Code				10g. Citizen	of What Cou	ntry?
	h with	Funeral Director	8216 Longpoint	Road				2122	2				USA	
	deat deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Deced	ent of Hi	ispanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14. F	lace - Ameri	
36	or ft		1 Never Married 2 Marrie	d 1 □Yes 2 □X If Yes, Give			1 ☐ Yes 2		Specify:		, , , , , , , , , , , , , , , , , , , ,			ite
Ö	72 hours after death with the Maryland natural', or Items 23a or 28a-f show digal Exacilier must be profified at	Completed by	3€Widowed 4 □ Divorced  15. Decedent's	Year or Dates:		16a Dece	dent's Usua	I Occup	ation			16b Kind o	Business/In	dustry
15	in 72	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or	5.1	(Give	kind of wor DO NOT us	k done d	durina mos	t of work	ing	100.14110	503.1103.011	addity.
212	e filed within al Hygiene. I other than " vent, the Ma	mo:	11 years	College (1-40)	3+)	Hous	sewife	€				Owr	1 Home	
Maryland 21215-0036	tal Hy d oth	Be (	17. Father's Name (First, Middle, L	ast)							e (First, Middle,		ame)	
yla	should be nd Mental marked o	Į.	Wilbert Wooden								)' Conne			
Mar	id 2 sh Ith and 27 Is rr Traurr		19a. Informant's Name/Relationsh Brenda Wooden	p (Туре, Print) niece							al Route Numbe Dundalk,			Code)
	1 and Health Iem 27		20a. Method of Disposition	THECE		lace of Dispo		Annie de la companya del la companya de la companya			Date	20c. Locatio		own, State
10 10	Pages nent of I ant: # Ite		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		1	ometery, crei ZView (				lav 2	24,2004	Baltin	ore C	ity MD
Baltimore,	그는 원급 .		21. Signature of Funeral Service L		ח									
<u> </u>	Depa Impo any ii		Chthony	(.(m	rel	ly	7110 8	sol1	ers P	oint	Iome Of Road,	Dundal	k,Md.	21222
15 67			23a. Part1. Enter the disease, or c shock, or heart failure. Ust o	omplications that cause nly one cause on each li	d the death ine.	n. Oolnot ent	er the mode	of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onseyand Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a. Strok	(le									Iday
	Examiner			Due to (or as	a rinsequ	ience of):	1						7	OUDDIE
	The state of	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Lu to (or as	a consequ	uence of):	1						- 3	years
	cuted nd ransit	Examiner	that initiated events	c										
Ó,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequ	uence of):								
8760,	cate b physic s the b	dicai	1	d					<del>.</del>					
9 X	death certific e attending pl d for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ncv						224	Date of delive	10.00 mg/
Вох	atten after I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pre						Month	Day Year
P.0.	that the de ed by the detached	hys	1 □ Yes 2 No 9 □ Unknown	9□ Unknown										
		by P	Part II. Other significant condition	is contributing to death b	out not resu	atting in the u	nderlying ca	use give	en in Part I.		23e. Did to	obacco use co	ontribute to t	he cause of death?
ord	v requires been sign should be										101	/es 2□No	3 ☐ Prot	pably 4 Unknown
Records,	aw is t	Completed									24a. Was	sy	prior to co	psy findings available mpletion of cause of
<u>~</u>	Th ate pag	Con									perfo	rmed? 2 No	death? 1 ☐ Yes	20 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ne.		h (Check only a			
of	Phys raldi	7: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatier 28b. Time o		A Bc. Injury	4 🗀 NU	-	me 5 Residence 1			(y)
on	Attending r death. sctor: After by the fune	ation	1 Natural 5 Pending 2 Accident investiga	(Month, Da	ay Year)	Injury	М	Work	<br Yes 2 □			, ,		
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determine		jury - At ho	me, farm, str	eet, factory,	office			28f. Location (S City or Tox		mber or Rura	I Route Number,
٥	tal or A	Cert		Dunding, of	to. (opour)	,	24072211		7-11-2		0.1.y 0, 7.0.	,, otalo,		_C_
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	(Check only 2 Medical E	Physician: To the best xaminer: On the basis o	of examinat	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	ie, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due to	tated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner st	ated.		29c.	License	number			29d. Date sig	ned (Month.	Dav. Year)
	with Con		)/	60	11	7			556	2	1			*
	1		30. Name and address of person w	no compliand cause of a	death June	23a) (Type.				La	to 14.1	D. /	- 01	11
			Union Men	iorial 1	4051	oita	1,0	lui	rei	-Si	Fil Pa	Kuc	ay B	2004 saltimore
W. Strategie	Sta Registi		31. Date filed (Month, Day, Year)		rar's Signal	ture	oe a				/	/	//	
- 7	riegisti	111	843Y 7 5 /	111/1 1/2/2007 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	. 16	4.07353	and the same							

		,	1 - For State AMEND TIFM #26	State of Maryland / Dep FER VERB 0831 5/25/06		Mental Hygiene	104 16631
	Physici /Medi		1. Decedent's Name (First, Middle, Las			2. Date of Death Month Day	3. Time of Death
	Examir		4a. Facility Name (If not institution, give 23 QUEENTRE	e court	4b. City, Town, or Location of Death  BACTIMOR	e BA	ty of Deeth ACTIMORE
ь	Funeral Director		5. Social Security Number 578 6. Security Number 11 Usuel Residence of Decedent	ex 7. Age (In yrs. last birthday ☐ M 2 ☑ F Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	with the Maryland is or 28a-f show	ector	10a. State 10b. County  MD BALTIN  10e. Street and Number	10Re BALT	ocation  MORC  101. Zip Code	10g Citizen of	10d. Inside City Limits 1 ☐ Yes 2 ②No  1 What Country?
	s 23a or	Funeral Director	23 QUEENTR		21244		Ase - American Indian,
5-0036	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28a-1 show other traumatic event, tra Madical Examiner must be required at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 254 No Specify:	o Rican, etc.) BI	ack, White, etc.
21215-0	withle 72 h iene. r than "natu ite Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th Crade	de completed) (Giv	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) TEACHER	rking	Business/Industry  INGTON D.C. SCHOOL
Maryland 2	should be filed within and Mental Hygiene. marked other than imatic event, Ita Mi	To Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maiden Surna GREGORY	ime)
-	and 2 sho ealth and m 27 is mu		19a. Informant's Name/Relationship (1	NKUN 23	ling Address (Street and Number or Ru QUEENTREE CO	URI BALTIM	ORE MD 21244
Baltimore	t. Page rtment c rtant: if		20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funaral Service Licen	LINCOLN	oosition (Name of ematory or other place)  MEMDRIAL DS	18/2004 SUITL	AND, MD
Ba	permi Depa Impo any ii		Dangh C		22. Name and Address of Facility VAUGHN C. GREEN ( 515) BAUTIMURE NATIO	DNALPIKE BALTI	WICES MURE MD 21229  Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Dementia  Due to (or as a consequence of):			Interval Between Onset and Death  > Zy ears
	Examiner	niner	Securitially list conclines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Dehyd R Due to (or as a contruence of):  H DERNA			~ lyear
8760,	eath certificate be executed attending physicien and for use as the burial-transit	icai Examiner	that initiated events resulting in death) Last	c. Due to (or s a consequence of):	- Ir early		chronic
P.O. Box 68	law requires that the death certificate be execu as been signed by the attending physicien and 2 should be detached for use as the burial-trail	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)	Δ	late of delivery Month Day Year
	w requires that been signed t should be det	þ	Part II. Other significant conditions or	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use con	ntribute to the cause of death?
Vital Records,	The ate h	Completed				24a. Was an autopsy performed? 1 Yes 2 No	. Were autopsy findings available prior to completion of cause of death?  1 Pes 2 No
Division of Vita	Attending Physicien: Th r death. sctor: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Actural 5 Pending investigation	Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: Hursing H	ath (Check only one)  lome 5 v esidence 6 On  28d. Describe how injury occu	
Divis	i i i i e	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a. Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause(s) and marred at the time, date and place	nanner as stated. , and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	2	29c. License number  D 5 8 77 4		ed (Month, Day, Year)
			ROSALYN E	completed cause of death (Item 23a) (Type 3AKER, MD	7141 Securit	Bival Ba	21244
40	Sta Registi		31. Date filed (Month, Day, Year)  MAY 2.5. 2004	32. Registrar's Signature	South		

		1 - For		ryland / D	epartmo	ent of Health and ate of Death		giene	_	1662
		1. Decedent's Name (First, Middle, La	st)				2. Date of De		-004	3. Time of Death
Physici		Robert A. Spi	riggs, Sr				May 19	), Day	004 Yeer	2135P
/Medic		4a. Fecility Name (If not institution, give			4b. C	ity, Town, or Location of De			County of Death	
		Mercy Medical	Center			Baltimore			N/A	
uneral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birtl	Mont	der 1 Year If Under 24 H	in. 8. Date of Bin (Month, Da NOV • 1 2	th v, Yeer)	9. Birth	place (State or Fore
irector			IM ZUF	02 1	rs.	,	Nov.12	,19	21	miny) MD
3		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Lin
faho	ō	MD N/A		Balt	timor	2				1 ☑ Yes 2 □
288-	rec	10e. Street and Number				Zip Code		10g. Citi	zen of What Cou	ntry?
3a or	ā	117 North Str	eeper Str	eet		21224		_	United	•
n result any water rygerie.  The 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Modical Examiner mast be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Anned Forces?	ver in U.S.	13. Was De	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No	-	14. Race - Ameri	
or its	F	1 ☐ Never Married 2 🛣 Married	1 X Yes 2 □ N	8/13-116		speciry Cuban, Mexican, Pu s 2⊠ No <i>Specify:</i>	erto Hican, etc.)	-	Black, White,	_
EX	d by	3 Widowed 4 Divorced	Year or Dates:	743-40	1 1 16	S ZAINO Specity:			Specify: B18	a C K
neto	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. I	Decedent's U (Give kind of	sual Occupation work done during most of v Tuse retired)	vorking	16b. Ki	nd of Business/Ir	ndustry
han M	m m	Elementary/Secondary (0-12)	College (1-4or 5-	-1	Labor				Shipyar	:d
arked other than		17. Father's Name (First, Middle, Last	)		Eabor		lame (First, Middle,	Maiden	Sumama)	
o po	Be	Russell Spri					ella Pe			
Tark	ပ္	19a. Informant's Name/Relationship (		10h	Mailing Adds	ess (Street and Number or				- O- d- \
7 is m traum		Carol M. Sprig				Streeper S				
em 27 other tr		20a. Method of Disposition	8p wile	20b. Place of cemetery			-		cation - City or To	
Y or		1 X Burial 2 Cremation 3				orest VA 20	26		ngs Mil	
important: If item 27 any injury or other tr		<ul> <li>4 □ Donation 5 □ Other (Specif</li> <li>21. Signature of Funeral Service Licer</li> </ul>		Pallis			04		_	•
any one		1 chun 2	ale	-	Salv	and Address of Facility In L. Will E. Baltim	iams Fu	nera	1 Home	, P.A.
vsician ledical aminer	liner	23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, a tary, hearing to man enter cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	c 10	ng cance		rest,		Approximate Interval Between Onset and Death
physician and is the burial-transit	edicai Examiner	resulting in death) Last	c.  Due to (or as a	consequence of	():					
by the attending phy tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 □Ectopid 5 □ Other	pregnancy (specify)		2	3d. Date of delive Month	ery Day Year
be det	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlyin	g cause given in Part I.	23e. Did to	bacco u	se contribute to the	ne cause of death?
should b	ed	hypercouce	mia_				1 U Y	′es 2[	□No 3 Prob	ably 4 Unkno
2 shoul	Completed						24a. Was		24b. Were auto	psy findings availa
page 2	E						autop perfor	TOPA?	death?	mpletion of cause o
± 5	0	25. Was case referred to medical				26. Place of D	eath (Check only of		, , , , ,	20110
S E	To B	examiner? 1 ☐ Yes 2 No	Hospital:	t 2 ER/Outp	patient 3	DOA Other: 4 Nursing	Home 5 ☐ Resid	ence 6	Other (Specifi	y)
After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day		me of ury	28c. Injury at Work?	28d. Describe h			
ctor: Af y the fur	atic	Natural 5 Pending investigation	1	. 54.7	М	1 ☐ Yes 2 ☐ No				
al Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc.	(Specify)			City or Tow	n, State)	l Number or Rura	_
To the Funeral D completely filled i	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of a and manner state	examination and	death occurre or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the c curred at the time, o	ause(s) a date and	and manner as st place, and due to	tated. the cause(s)
o the	Mec	29b. Signature and title of certifier	and manner state	a.		29c. License number		9d Date	signed (Month,	Day Year)
Ĕ 9		1000	1.0	_	1				10	
1 2		" Miser-	I WILL M	D		P17655		Mai	4 14, 2	004
		30. Name and address of person who	completed cause of dea	ain (Item 23a) (T	ype, Print)					
+/		1001:2 P 10-	ol T.L.	7 ~.	C1 1	Paul Pl. B	no I time	~2	MN 7	1201

State of Maryland / Department of Health and Mental Hygiene 16633 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 18, **Physician** 11:30а м 2004 May Eleanor Maury Thompson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Casey House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Y June 12, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F 79 465-30-5509 1924 New Jersey Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4906 Glen Cove Parkway 20816 United States death Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married 1 □ Yes 2\DXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If Item 27 is markad other the any injury or other traumatic event. housewife housewife 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Brice Alfred Blake Maury ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myron E. Thompson/Husband 4906 Glen Cove Parkway, Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 Cremation 3 Removal from State 5/21/04 Baltimore, MD 4 Donation 5 Other (Specify) Baltimore Crematory at LP 21. Si mature of Funeral Service Fensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine signed by the attending physician and does detached for use as the burial-transit Due to (or as a consequence of) Box 68760 certificate be Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2XXNo Month Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. þ 1 ☐ Yes 2 ☐ No 3 X X robably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has XXNo 1 Tes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 XX ther (Specify) 1 ☐ Yes 2 ▼No 1 Inpatient ို 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XX atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ar title of D35635 May 18, 20004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD Dr. Joseph Kaplan, 32. Registrar's Signarare 31. Date filed (Month, Day, Year) State MAY 2 5 2004 Registrar

		-	For State Registrar	State of Ma	aryland / De <sub>l</sub> <i>Ce</i>	partment of leartificate of			giene Reg. No. 2	004	16634
	Physicia		Decedent's Name (First, Middle, La  MARY MISK	st) <b>THOMPSO</b>	ON			2. Date of De Month <b>May</b>	Day 22	2004	3. Time of Death 11:15a. M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town,	or Location of Dear	h		nty of Death	
	Lxaiiiii	<u> </u>	117 Upnor Road			_ 1	imore		n/		
	Funeral Director		215-03-4188	6ex 7. Ag 1 □ M 2 💢 F	e (In yrs. last birthda 86 Yrs.	Months Days			1917	Coun	lace (State or Foreign itry) Sylvania
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  n/a		10c. City, Town or					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen o		ntry?
	23a c	aiD	117 Upnor Roa			2121			U.S		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiane.  If item 27 is marked other than "natural", or Items 23s or 28s-f show or other treumatic event, the Marildal Eraniner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	1	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ▼ No	ban, mexican, Pue	Specify Yes or No to Rican, etc.)	- 14. R	lace - Americ lack, White, cify: Whi	etc.
9	2 hou	ted	15. Decedent's E	ducation	16a. De	cedent's Usual Occi	upation	orkina	16b. Kind of	Business/Ind	dustry
21215-0036	thin 7 e. an "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	5+) life	<ol> <li>DO NOT use retir</li> </ol>	ed)	many	m 1		
2	filed with Hygiene sther thai	S	75 - 1 1 1 2 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1	3 yrs	. De	partment		me (First, Middle	Teleco		cation
Maryland	should be fill and Mental H marked off umatic even	To Be	17. Father's Name (First, Middle, Las Peter	0	Misk		Katl	nerine		Cyml	bryla
lar	2 sho and is mu reum		19a. Informant's Name/Relationship			ailing Address (Stree					
	1 and 2 Health em 27 i		Doug Miskew (ne	phew)	20b. Place of Dis	Crystlew sposition (Name of		Date		n - City or To	
יסר	Pages nent of H int: If ite		1 Burial 2 Cremation 3			rematory or other pi	·	29_0/	Rolti	more M	aryland
Baltimore,			4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Lorraii	ne Park 22. Name and Add	-	28-04		nore, r	arytain
Ba	permit. Departr Importe eny inju		Polesth	1 Know		Mitche 6500	York Road	reld F.H. 1 Baltim	. inc. ore.Mar	vland	21212
	5 3	Г	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	d the death. Do not				-	,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		40 Scier	ume Ch	WIO VAZ	WIAM.	DISON	35 7	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	307.00 011	101112	00110			
	Examiner		Sequentially list conditions		ENTEN:	sion				7	Zoyns
	sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (dr as	a consequence of):						
	and and Il-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
760,	be es sician buria	icalE		. d							
687	ficate physics the	edic		d			0.0		1		
Box	death certificate be executed e attending physician and nd for use as the burial-transit	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pregnar	1CV		t t	Date of delive	•
	0 0	icia	in the past 12 months?	4☐Pregnant a		5 Other (specify)				Month	Day Year
P.0	at the by th	hys	9 Unknown					aa- Did		antributa ta t	he cause of death?
Records, F	w requires that the sbeen signed by th should be detache	Completed by Physician/Med	Part II. Other significant conditions	FIBNUS		e underlying cause (	given in Part I.		Yes 2 No		pably 4 □Unknown
ecc	aw S S D	piet	Bronutreu	ASIJ				24a. Was	an 24	b. Were auto	ppsy findings available impletion of cause of
<u></u>	Thate Page	200	CA BRETT	× -				1 ☐ Yes	ormed? 2'⊠No	death?	2 No
/ita	yelcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hespital:			)th ar	eath (Check only			
of Vital	this al di	2	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inji		tient 3 DOA	Other: 4 Nursing	Home Res 28d. Des ribe	idence 6 🗆		(y)
no	ling After fune	ion	1 Natural 5 Pending	(Month, Da	ay Year) Inju	ry W	iork? □ Yes 2 □ No	200. 0 100.01			
Division	al or Attending F s after death. Il Director: After id in by the funer	Certification:	3 Suicide 6 Could not	be 28e. Place of In	ijury - At home, farm	, street, factory, offic	:0			mber or Rura	al Route Number,
Div	after Dire	erti	4  Homicide	building, e	tc. (Specify)			City or 10	wn, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier Certifying F	Physician: To the best aminer: On the basis and manner s	of examination and/o	eath occurred at the r investigation, in m	time, date and pla y opinion, death oc	ce, and due to the	cause(s) and date and place	manner as s ce, and due to	stated. o the cause(s)
	o the o the omple	Med	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date sig	gned (Month,	Day, Year)
	F ≥ F ŏ		D Vin	+ AD	In So	D	88200	12	5/2	4/04	1
	10		30. Name and address of person wh	o completed cause of	death (Item 23a) (Ty	pe, Print)					
			Vincent Dipi	etro MD 7	801 York	Road Ba	ltimore,M	d. 21212			
	St Regist	ate trar	Vincent Dipi	32. Regist	trar's Signature	poores	/	_ <b></b>			

			State	of Maryland / Dep	artment o	of Health a	nd Me	ental Hygie	ene 2	0 N L	16	635
			Registrar	Ce	rtificate (	of Death		Reg	. No.		3. Time of	
	Physicia	an	Decedent's Name (First, Middle, Last)     Nannie Grace Taorm	ino				Month	Day	Yeer	6:20	7.55
	/Medic	al	4a. Fecility Name (If not institution, give street and		4h City Tow	wn, or Location of		May 2	2 2 4c. Count	004 of Deeth		
	Examin	er	3315 Batavia Aven			Baltimo			n/a	a		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	If Under 1 Y	fear If Under 2	4 Hrs. g	B. Date of Birth (Month, Day, Y			lace (State or	r Foreign
	Director		212-26-3825 1□M 25xf	76 Yrs.	Months Da	ays Hours	Min.	10-12-1	927	Wes	t Vir	ginia
	2		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation					1	0d. Inside Cit	v Limits
	anyla ehov	_	MD 10b. County n/a	Baltimo							1 <b>X</b> □Yes	
	the M	Funeral Director	10e, Street and Number		10f. Zip Co	ode		100	. Citizen of	What Cour	ntry?	
	with with	₫	3315 Batavia Avenu	2	212				USA			
	death	era	11 Marital Status 12. Was D		Was Decedent	t of Hispanic Origi Cuban, Mexican,	in? (Speci	ify Yes or No-		ce - Americ		
0	or Ite	Fur		s 2 No		No Specify:	r delto in	ican, etc.,	Speci		ite	
3	be tied within 72 hours after death with the Maryland Hygiene. Hygiene. Ad other than "natural", or items 23a or 28a-f ehow do other than "natural", or items 23a or 28a-f ehow event, the Madical Examiner main be notified at	d by	3X Widowed 4 □ Divorced Year of	r Dates:				1				
5	"nati	Completed	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Dece (Give	edent's Usual O Bikind of work d DO NOT use n	occupation done during most retired)	of working	7	Bb. Kind of E	susiness/in	dustry	
7	withir ene. then	mc	Elementary/Secondary (0-12) Colleg	9 (1-40r 5+)	Homema				In o	wn h	ome	
7	Hygi Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)					First, Middle, Ma				
2	2 should be t and Mental I is marked of sumatic eve	To B	Page Amos Shinaber	ry			Leor	na Grac	e Bu	rner		
a	s 1 and 2 should f Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print)	daughter 19b. Mail	ing Address (S	itreet and Number	r or Rural	Route Number,	City or Town	, State, Zip	Code)	
2	2 4 Z 5		Patricia L.Klapka			front 1	Rd.					2121
ore	es 1 al of Hea If item or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr	20b. Place of Disp cemetery, cre		, in			Oc. Location		rylan	٦
È	Pages tment of tant: If it jury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Belair		aruen				•		
Baitimor	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Licensee  Maria H. Zan	mi) 2	63 S.	Address of Facility  Conkli	ng S	St. Bal	timo			224
	Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):	D	TCy D					Approximate Interval Betto Onset and Conset	ween
U. BOX 68/60,	The faw requires that the death certificate be executed the same been signed by the attending physician and the bound be detached for use as the burial-transit and	Physician/Medical Exal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ver   V		□Ectopic pregi	nancy		5.7		ate of deliv		f ear
عذ	res that the signed by be detact	þ	Part II. Other significant conditions contributing	to death but not resulting in the	underlying caus	se given in Part I.		1			he cause of d	
Ö	requi	eted						24a. Was an		Ware aut	opsy findings	available
Vital Records,	The far ate has page 2	Completed	hypothyron	<u></u>				autopsy		prior to co death? 1  Yes	impletion of c	ause of
VII.	icien Sertific ector	Be	25. Was case referred to medical examiner?			Othor		(Check only one				
	Physicien: this certific ral director,	10	1 Tes 2 De la	Inpatient 2 ER/Outpatient ate of Injury 28b. Time		4 Nul		se 5 Resider			fy)	
0	ding F h. Alter funer	tion	1 Natural 5 Pending 2 Accident investigation	Month, Day Year) Injury	м	: Injury at Work? 1 ☐ Yes 2 ☐ N			. ,			
Division of	or Attending Physicien: after death. Director: After this certific in by the funeral director,	Certification:	3 Suicide 6 Could not be 28e. F	lace of Injury - At home, farm, suilding, etc. (Specify)	street, factory, o	office	2	8f. Location (Str. City or Town,		nber or Rur	al Route Num	ber,
_	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fur	edical Ce	(Check only 2 Medical Examiner: On the	o the best of my knowledge, dea ne basis of examination and/or manner stated.								s)
	thin 2 the omplei	Med	29b. Signature and fittle of certifier	namer stated.	29c. L	License number		29	d. Date sign	ed (Month,	Day, Year)	
	F \$ F 8				philippin immand	1272	46		0	- 4	:04	
	9		30. Name and address of person who completed	cause of death (Item 23a) (Type 2801 HuPS	-	BACT		RE M	D. 21	224		
	St	ate		Registrar's Signature				- {				
	Regist		MAY 2 5 2004	Registrar's Signature	enter							

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Gwendolyn Ianthe Tracey May 20, 2004 12:05 PM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Riverview Nursing Home Baltimore Co. Essex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 20 F Yrs 218-34-1207 Oct. 11, 1911 Maine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk 1 ☐ Yes 2X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 7702 Meath Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ZHNo Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ukn. Ukn. Vonethel Perkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martha L. Yarworth/Daughter 7702 Meath Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 5/24/2004 Middle River, Maryland 21. Sign tu v of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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, Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "neture" any injury or other treumatic excent any injury or other treumatic excent any injury or other treumatic excent any injury or other treumatic excent any injury or other treumatic excent any injury or other treumatic excent and injury or other excent and injury

the bunel-transi

Examine Physician/Medical Completed by Be Certification: To

Medicai

State Registrar 29b. Signature and title of certifier

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, illed in by the fu 24 hours

within 24 hou

To the Fune

completely fi

Part II. Other significant conditions of	ontributing to death but not res	sutting in the underlying	g cause given in Paπ I.	1 ☐ Yes 2 No	ntribute to the cause of deeth?  3 Probably 4 Unknown
Sacral	decubitus	ulcar		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1  Yes 2  No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, street, fact fy)	ory, office	28f. Location (Street and Numb City or Town, State)	per or Rural Route Number,

SEBAST IAN JOITN

3023 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

EMTERN AVENUE

0 0055171

29d. Date signed (Manth, Day, Year)

21/04

BALTIMORE MD 21224

		4	For State	State of Maryland	d / Department of He Certificate of D		ntal Hygiene Reg. No	Z 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	16637
			Registrar  1. Decedent's Name (First, Middle, Last)		Octimodio of D		Date of Death		3. Time of Death
	Physicia /Medic	in ai	Mary Maro	OLI CO	Uat  4b. City, Jown, or L	agation of Dooth	May 2	2, 2004 County of Death	10:48A.M
2	Examin	er	4a. Facility Name (If not institution, give s	20:	DARU	1/1/1/	1	BAITIM	NOF
	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs. la	ast birthday) If Under 1 Year Months Days	VICCO	Date of Birth (Month, Day, Year)	91.01	lace (State or Foreign
	Director		Usual Residence of Decedent					1	0d. Inside City Limits
	arylan show	_	10a. State 10b. County		r, Town or Location			,	1 ☐ Yes 2 No
	he Ma	ecto	10e. Street and Number	mort	10f. Zip Code		10g. Ci	tizen of What Coun	ntry?
	death with the Maryland ime 23s or 28s-f show	Dir	9004 HINES	Rd.	213	134		USA	
	death	Funeral Director		12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Speci n, Mexican, Puerto Ri	y Yes or No- can, etc.)	14. Race - Americ Black, White,	
920	be filed within 72 hours after death with the Marylan nat Hygiene.  ed other than natural; or lieme 23s or 28s-f show event, the Madical Exeminer must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	1 □ Yes 2 No	Specify:		Specify: U	hite.
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation completed)	16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	uring most of working		(ind of Business/In	dustry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Secretary		Bar	k Bind	ers Union
d 2	e filed within al Hygiene. I other than vent, the Ma	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name (			
ılan	should be nd Mental marked c	To B	Henry F. R.	ssendale.		Margo	aret 0	Brier	2
Maryland 21215-0036	2 sho and is mu		19a, Informant Name/Relationship (7)	pe, Print)	19b. Mailing Address (Street a	nd Number or Rughl I	Route Number, City	or Town, State, Zip	Code)
_	of Health item 27	1	20a. Method of Disposition	Wheat 20b. P	Place of Disposition (Name of	Da	19 20c. L	ocation - City or To	own, State
nor	0 0 = =		1  Burial 2  Cremation 3  □ F  '4 □Donation 5 □ Other (Specify)	lemoval from State	remetery, crematory or other place fise on's lame te	- 71	-04 PA	KTT mor	RE MA
Baltimore	그 든 원 등	1	21. Signature of Funeral Service Licens	91.	22. Name and Address	s of Facility BA	LTIMOR	e mo	21234.
ä	Depared Important in any ire	9	Ambelly	1. Jayotky	EVANS FUR		APEL 88	20 HAR	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death ne cause on each line.	h. Do not enter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
A	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	& Myseller	Heart for	Mene	-14	peur
	Examiner				- Carlot Co. J.				_
er find	<b>P</b> #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):				
	and and Il-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	(uence of):				
120	death certificate be executed the attending physician and ad for use as the burial-transit			d					
9	rtificati ng phy as th	Physician/Medicai	IF FEMALE:						
Box	leath certifica attending ph I for use as th	lan/	23b. Was decedent pregnant in the past 12 Months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3 Ectopic pregnancy			23d. Date of deliv Month	Pery Day Year
0	that the de ed by the a detached f	ysic	1 Yes 2 No 9 Unknown	9 Unknown	John (Spoolly)				
0	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significent conditions co	ntributing to death but not res	sulting in the underlying cause give	en in Part I.			the cause of death?
ords	w require been sig should b	ted t	and stage fler	ili semen	Un		1 🗆 Yes		
Records,	lawr nas be	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
	r: The icate h					26. Place of Death	1 ☐ Yes 2 ☐ N	lo 1 □ Yes	2 No
Vit	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	` .	e 5 Residence	6 □Other (Spec	ify)
o of	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Work	k?	8d. Describe how in	ury occurred	
Sior	Attending r dea h. e tor After by the fune	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by			Yes 2 □No	8f. Location (Street	and Number or Bu	ral Route Number
Division of Vital	or Att	Certification:	4 Homicide determined	building, etc. (Speci	nome, farm, street, factory, office ify)		City or Town, Sta		
_	To the Hospital or Attendii within 24 hours after dea.h. To the Funeral Director A completely filled in by the the	ledical Co	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	niner: On the basis of examin-	owledge, death occurred at the tin ation and/or investigation, in my o	me, date and place, a ppinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as ind place, and due	stated. to the cause(s)
	the H	Medi	29b. Signature and title of certifler	and manner stated.	29c. Licens	e number	29d. D	Date signed (Month	n, Day, Year)
	7 × 5 0		The second of th	mundo, ME	0 059	1578	5/	25/04	
	V	)	30. Name and address of person wh		em 23a) (Type, Print)	1	0.01	-2-0	01200
_			MARATHA RAGAL	INMAD 54	eOI Larn Rai	un Ber	Baltin	me mi	21251
	<sub>A</sub> S	tate	31. Day (144) (147) (147)	32 Ragistrar's Sign	spouls				

			1 - For State Registrer	State of Maryland	Department of Certificate of	f Health and N		ne 2001	16638
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Las	B. Water	5	n, or Location of Death	Mayo	Day Year 33 2004 4c. County of Death	3. Time of Death
	Funeral Director		FRANKLIN WOC 5. Social Security Number 6. Se	ds	Ros	edale lar If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	BALTIMO	SRE ace (State or Foreign try) YCAND
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Mcdical Examitter: ust be notified at ones.	To Be Completed by Funeral Director	10a. State 10b. County  VA GOUCE  10e. Street and Number  8 201 Mande  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edice (Specify only highest grade)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  19a. Info ant's Name/Relationship (7)  19a. Info ant's Name/Relationship (7)  20a. Method of Disposition 1 Burial 2 (Cremation 3 F 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	12. Was Decedent Ever in U.S. Amped Forces? 1 MYes 2 No 1 Myes 2 No 1 Myes 2 No 1 Myes (ive Year or Dates:  Cation (a completed)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	13. Was Decedent of If Yes, specify C  1 Yes, specify C  1 Yes, specify C  1 Yes, specify C  1 Yes, specify C  1 On Not use refund of work doing if the work doing if the work doing if the work doing if the work doing if the work if the work doing	of Hispanic Origin? (Spuban, Mexican, Puerto No Specify:  Supation ne during most of work irred)  18. Mother's Name  Mary	acity Yes or No-Rican, etc.)  16b.  16b.  16c.	Citizen of What Count  USP  14. Race - America Black, White, e Specify: W  Kind of Business/Indi  2. MCO Ste en Sumame)  V or Town, State, Zip of Location - City or Tow  CST HILL  MD 2123	an Indian, onc.  If Code)  Why State  MO  34.
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P.O. Box 68	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnar 5 Other (specify)	ncy		23d. Date of delivery Month D	/ Pay Year
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Vital Records,	The ate h page	e Comple	25. Was case referred to medical				24a. Was an autopsy performed?	<ul> <li>prior to come</li> </ul>	y findings available pletion of cause of
Division of Vi	ling Phys ). After this funeral di	To B	examiner?  1  Yes No  27. Manner of Death  1  Natural 5  Pending 2  Accident investigation		Time of 28c. Inj		(Check only one) ne 5 ☐ Residence 8d. Describe how inju		
Divi	To the Hospital or Attanc within 24 hours after death To the Funeral Diractor: completely filled in by the	al Certification;	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify) icien: To the best of my knowleds			8f. Location (Street a City or Town, Stat	e)	
	To the Howithin 24 h To the Fur	Medical	(Check only 2 Medicel Examirone)  29b. Signature and title of certifier	er: On the basis of examination a and manner stated.	.nd/or investigation, in my	opinion, death occurre	d at the time, date an	d place, and due to the attention of the signed (Month, Da	ne cause(s)
)	0,		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print)	45475	5	24/0	7
	Sta	te	Monamma d 31. Date filed (Month, Day, Year) MAY 2 5 200	Kannama		9512 HAR	LFORD RD	BALTIM	1234. 10RE MO
	Registr	ar	IVIAT Z 5 ZUL	14	In sport				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** Bealin Isaac Witherspoon May
4b. City, Town, or Location of Death 2004 6:20pm /Medical 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Future Care Nuring Home Baltimore if Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours M 2□ F Yrs Director 251-26-7381 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23e or 28e-f sho the Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number U.S.A. 21223 1951 West Fayette Street 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Yeer or Detes: 1 Never Married Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laborer Maryland Drydock 7th grade na permit. Pages 1 and 2 should be file.
Depertment of Haaith and Mental Hy,
important: if tiem 27 is marked other
eny injury or other traument. traumatic event. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Brayboy Martin Witherspoon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 07514 19a. Informant's Name/Relationship (Type, Print) 495 East 19th Street Apt 1D, Patterson, NJ Otis Witherspoon-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/27/04 Baltimore, Md Zion Cemetery 21. Signature of Funeral Service Licenses March F/H West 21215 4300 Wabash Ave, Baltimore Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be axe Division of Vital Records. P.O. Box 68760. Herocientic Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 27. Menner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours eftar death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) oyal Ave Balt MD 21217 MO 1)61 1600 West 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar MAY 2 5 2004

**DHMH 16 Rev 6/95** 

			1 - For State Registrar	State of Mar		artment of H			giene Reg. No. 200	4 16640
	Physic /Medi	w-	1. Decedent's Name (First, Middle, Las		215			2. Date of Dea	Day J Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give	e street and number)	(In yrs. last birthday)	- Committee of the Comm	Location of Death  1 U M  If Under 24 Hrs.		4c. County of De	ath TIMOVE
. 20	Funeral Director		215-09-8698 Usual Residence of Decedent	□M 2XF 88		Months Days	Hours Min.	8. Date of Birth (Month, Day May 22,	1916 N	irthplace (State or Foreign Sountry) Maryland
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Itam 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avent, the Medical Examinar must be notified at	irector	10a. State 10b. County  MD Baltimor  10e. Street and Number		Oc. City, Town or Lo	cation 10f. Zip Code			log. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No Country?
	ter death with Items 23a or ner must be r	Completed by Funeral Director	2300 Dulaney Valle 11. Marital Status	12. Was Decedent Eve Armed Forces?		21093 Was Decedent of His 1 Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	United St	erican Indian,
-0036	hours after atural; or l	ed by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ XNo	Specify:		Specify:	White
21215-0036	d within 72 giene. er than "na	omplet	(Specify only highest grade Elementary/Secondary (0·12) 12	de completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired) Secretary	urina most of workir		Building F	,
Maryland	should be filed within 72 hours aft ind Mental Hygiene. s marked other than "natural; or umatic avent, the Medical Exem	To Be	17. Father's Name (First, Middle, Last) Andrew Kellner				18. Mother's Name Lillian	Winke	lmann	
	1 and 2 sho Health and am 27 is m		19a. Informant's Name/Relationship (T.  Janet Brendel –  20a. Method of Disposition	Daughter		Timberkno	ll Lane	Ellicot	t City, MD	21042
Baltimore,	Pa First		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signal use of Fyneral Service/Ten)	Removal from State	Gardens (	natory or other place of Faith	05/26	/2004	20c. Location - City o	e, MD
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	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	e De	ement				Interval Between Onset and Death
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Ď	spital or ours afte ours afte ours afte		4 ☐ Homicide determined  29a. Certifier 1 ☐ Certifying Phy	building, etc. (S	opecity)	occurred at the time	date and place, as	City or Town	, State)	
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1	5		30. Nam d address of person who co			•	>2 /4	U	May	5 th soot
	Sta	te	31. Data AND UT DO TOTAL	M.D. 2300	DULANEY 1	VALLEY ROL	AD TIMON.	IUM, MD	21093	

DHMH 17 Rev 1/2001

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MAY 23, 2004

				1- State of M State of M	aryland / D	epartment of Certificate of	f Health and N of Death	1ental Hy	giene Reg. No. 2 ()	04	16641
		Physic	ian	Decedent's Name (First, Middle, Last)				2. Date of De	nath Day	Year	3. Time of Death
		/Medi Exami	cal	Earl Willian  4a. Facility Name (If not institution, give street and number)		nan, Sr.	n, or Location of Death	May 23	3, 2004 4c. County		8:35pm M
	1			Greater Baltimore Medical	Center	Towsor			Balti		
		Funeral Director		5. Social Security Number 214-20-7198  Usual Residence of Decedent  5. Sex 1 M 2 F	ge (In yrs. last birth 93 Y	nday) If Under 1 Ye Months Day		8. Date of Bir (Month Da NOV 2,	1910	9. Birthp Cour Mar	place (State or Foreign ntry) y l and
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		Jeath The 23	Funeral	15200 Old York Road 11. Marital Status 12. Was Decedent	Ever in U.S.		111	ecify Voe or No	U.S		an Indian,
1	5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itams 23a or 28a-f ehow evant. The Medical Exam natural be notified at	by	Amed Forces?  1 Never Married 2 Married  1 Yes Sive Year or Dates:		If Yes, specify C	of Hispanic Origin? (Spoudan, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Specify	k, White,	
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		5		30. Name and address of person who completed cause of de	path (Item 23a) (Tyl	pe, Print)	80852 + Bel+	MD	21 201	7	
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			Registrar		Certifica	ile oi Dealii			1 1 12 12 12
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	/Medic	_	Yvonne 4e. Fecility Name (If not institution, give	e street and number)	4b. Cit	y, Town, or Location of De	ath	4c. County of Dea	th
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Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Licer	ison L	March	and Address of Facility TF/H West			
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o,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
760,	le be ysici e bu	cai		d					
68	leath certificate t attending physic for use as the b	edl							
×	iding ise a	M	IF FEMALE:	23c. If yes, outcome of pregna	ancy			23d. Date of de	alivery
Вох	ath atter for u	- Ca	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Feta 4☐Pregnant at time of c				Month	Day Year
	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	death 5 Cher	(Specify)			
P.O.	= > S	by Physician/Medl					an Did		
· v	iw requires that s been signed to should be deta	λ	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.		tobacco use contribute l	
/5	quir on si	pa					_ 1 🗆	Yes 2 No 3 P	robably 4 Unknown
10/18	w re bee	Completed					24a. Was	an 24b. Were a	utopsy findings available
Se Se	The taw cate has page 2:	E G					<ul> <li>auto</li> <li>perfe</li> </ul>	psy prior to death?	completion of cause of
=	: Th	ပ္ပ					1 ☐ Yes	2 ☐ No 1 ☐ Ye	s 22 No
of Vital Record	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?				Death (Check only	one)	
1	s s	ဥ	1 ☐ Yes 2 ☐ M6	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursin	g Home 5 ☐ Res	dence 6 Other (Spe	ecify)
	g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
Ò	Attending ir death. ector: After by the fune	읥	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		M	1 ☐ Yes 2 ☐ No			
<u></u>	otor ctor y th	Ę.	3 ☐ Suicide 6 ☐ Could not b	286. Place of injury - At n	nome, farm, street, fact	tory, office		Street and Number or F	Tural Route Number,
Division	or / after Dire	ertiflcation:	4  Homicide	building, etc. (Speci	ify)		City or To	wn, State)	
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	Hospital 24 hours a Funeral I tety filled	edical	(Check only 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination	ation and/or investigati	ed at the time, date and pi ion, in my opinion, death o	ace, and due to the ccurred at the time,	date and place, and du	e to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	led	one)	and manner stated.		00-1		and Day siched (Man	th Class Variable
	To with	Σ	29b. Signature and title of certifier			29c. License number		29d. Date signed (Mon	(n, Day, Year)
T			1	2		8949		5/20	1010
	Y)		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	1		17	1
			lean Dlive	nto MD	CD M	anland	Gene	al to	sotal
	Sta	to.	31. Date filed (Month, Day, Year)	32. Begistrar's Sign	ature				
	Registr		MAY 2 5 20		19 11	parket			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** C/ A M Delphia Α. Woods 200% /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 927 RACTIMONE EULTE 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days PA. 1 ☐ M 2 🗓 F 76 214-24-9784 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avent. The Madical Examiner must be notified at Director 1 ☐ Yes 2 1 No MD. Harford Belair 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1112 Emerald Road 21014 USA or items 23a 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ☐Yes 2X No Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ 3X Widowed 4 □ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years **HOusewife** Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H is marked of John Angelini Brigida Sorrento 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heatth ar Important: if item 27 ts any injury or other trau once. Charles Woods 1112 Emerald Road, Belair, MD, 21014 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State May 24,2004 Baltimore City, MD. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Demic /Medical ORONAL Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed 0 and-tran: physician a s the burial-Box 68760 by Physician/Medicai the attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan has autopsy 1 ☐ Yes of Vital 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending Division 5 Pending investigation s after death.
I Dirsctor: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00056851 05/211 04 30. Name an ess of person who completed cause of death (Item 23a) (Type, Print) 2000 Franklin Square Orice Baltinore MD21237 MA 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 2 5 2004

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** 2:15 PM Walter John Williams May 1 2004 33 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Square Hospital Center Franklin 8. Date of Birth (Month, Day, Year) April 24,1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Days 1 M 2 □ F Hours Mary I and 219-07-1240 85 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Exaction coust to notified at 1 Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 U.S.A. 1217 Berk Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW I I 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: White 1 Yes 2 No 5-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2121 id Mental Hyglene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Assembler Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) and 17. Father's Name (First, Middle, Last) Be 9 and Mental Smith John Williams Lizzie Mae Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lopertment of Health an Importent: If Item 27 Is m. any injury or other 2006. Baltimore, Maryland 21221 Mrs. Thea Misher -Friend 1910 Sue Creek Drive Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 5/27/04 Baltimore, Maryland Leonard J. Ruck, Inc. Cain 22. Name and Address of Facility Heather 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 Heather 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Strcke Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed attending physicien and for use as the burlal-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, HPN 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 No certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No 2 this After thi 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Division Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation after death, Director: Aff d in by the fur 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ů, To the within 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier ౖ uahakah IN em Res 00000 May 23, 2004

State Registrar

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Registrar MAY 2 5 2004

DHMH 17 Rev 1/2001

Sudhakar Papineni 31. Date filed (Month, Day, Year)

ORIGINAL

9000 Franklin Square Drive Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

04-03355 SKEETER WOOD WHM

			1 - For Unpend Item Registrar	State of #23a,27,28a	Marylan I <b>per m</b>	d/Dep:	artment 12/04 tilicate	of He	ealth a <i>eath</i>	ınd M	ental Hy	gien Reg. No	20	0 i,	1664
			1. Decedent's Name (First, Midd								2. Date of De	aath		Year	3. Time of Death
	Physici /Medi		SKEETER LEE	WOOD							MAY 1	8, 2	004		7:56 P
	Examir		4a. Fecility Name (If not institution MERCY MEDICAL		iber)			IMOF	E CI	TY		40	. County	of Death	
	Funeral Director		5. Social Security Number $231-94-2936$	6. Sex 1 M 2 ☐ F	7. Age (In yrs. 44	last birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min	8. Date of Bi (Month, Di 09/20	av. Year	59	9. Birthpl Coun RHOI	
	land		Usual Residence of Decedent  10a. State 10b. County	,	10c. Cit	y, Town or Lo	ocation							10	Od. Inside City Limit
	the Marylan 28a-f show notified at	to	VA.		V	IRGIN	IA BE	ACH							1 XYes 2 □ N
	with the a or 28a be noti	Funeral Director	10e. Street and Number 3726 JEFFERS	ON BLVD			10f. Zip C	345	5.	,		10g. Ci	tizen of V	Vhat Coun	try?
	ns 23a	erai	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.				ain? (Spe	cify Yes or N	o- T		e - Americ	an Indian,
20	s 1 and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23a or 28a-1 show other treumatic event, the Madical Examinar must be notified at	by Fun	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried Armed For	ces? 2 <b>∑</b> No ∍		If Yes, specif 1 ☐ Yes 2		Mexican, Specify:	, Puèrto f	cify Yes or Na Rican, etc.)			k, White, 6	
ž	72 hours natural',	ted		nt's Education			dent's Usual			afaddia		16b. F	Cind of Bu	siness/Ind	lustry
21212-0030	should be filed within 7 and Mental Hygiene. Is marked other then "n eumatic event, the Mad	Completed	(Specify only higher Elementary/Secondary (0-12) 12YRS	College (1-	4or 5+)	life.	kind of work DO NOT use ABLED	retired)	ring most	or workir	ng	N,	/A		
g	be filed ital Hygi of other event, I	BeC	17. Father's Name (First, Middle,								(First, Middle	, Maidei	n Sumam	e)	
Maryland	should to nd Ment marked umatic e	70	JAMES LEE WO						DORI						
	12 sh h and 7 Is m reum		19a. Informant's Name/Relations		D )						Route Numb				<sup>Code)</sup> CH,VA234
	ges 1 and 3 of Health If item 27.		SHIRLEY BLOU  20a. Method of Disposition	NT (SISTE	20b. F	Place of Dispo	sition (Name	e of			ate VI			City or To	
<u> </u>	ages ant of t: If it		1 Burial 2 Cremation '4 Donetion 5 Other (5			emetery, crei DDLAWI	natory or oth	er place)		IS05	/22/0			•	
pailillore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service			22 F	2. Name and HENRY	Address W •	of Facility JEN	KINS	5 & S(	ONS	co.		
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that ca	used the deat						ONKTOI r respiratory a		) •		Approximate Interval Between
0,00,	Physician / Medical Examiner transit the prival-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (d	or as a consequence or a consequence or a consequ	uence of):	ne Intoz	xicat.	ion						
.C. DOY OC	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta int at time of d	I death 3	Ectopic preg Other (spec						23d. Date Mor	e of deliver	y Day Year
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Vital	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medica examiner?	Hospital:				Other			(Check only				
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DIVISION	or Attending after death. Director: After In by the fune	Certification;	2 Accident 3 Suicide 4 Homicide	not be a sined 28e. Place buildin	of Injury - At ho g, etc. (Specif	ome, farm, str y)	-		A	2		Street ar	300°	BIK.S	Route Number.
-	Hospite 4 hours Funerel ely filler	edicai Ce		ng Physicien: To the Exeminer: On the ba	best of my kno sis of examina					place, a	nd due to the	cause(s	) and mar		
	To the within 2 To the complet	Med	29b. Signature and title of certifie	and mann	or stated.		29c. I	License r	number			29 <b>d</b> . Da	te signed	(Month, D	ay, Year)
	₩ F 8		DI.	() +	Z(Y)	0 .		ОС						2004	
			60. Name and address of person	who completed cause	of death (Iten	23a) (Type	Print)								
	<u> </u>		31. Date filed (Month, Day, Year,		gistrar's Signa	1	0444	Pen	n St	reet,	, Balt:	imor	e, Ma	aryla	nd 21201
	Sta Registi	0	MAY 2 5 20	04	1 1	Spark									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16647 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month 18, **Physician** Mary Dorothy Ambrose 2004 1712 May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Allegany McCoole 25011 Crook Ave., SW | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 13, 1937 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 STF Months 214-36-6556 Director 66 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show mast be notified at MCCoole Allegany 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 21562 25011 Crook Ave., SW Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 end 2 should be filed within 72 hours after on ant of Health end Mental Hygiene. Int: If Item 27 is marked other than "natural; or iter 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 20 No Specify: white 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Laverne Rowan Robert Edward Kirkwood ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25011 Crook Ave., SW MCCOOle, MD 21562 19a. Informant's Name/Relationship (Type, Print) William Ambrose/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: if Ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/21/04 Restlawn Memorial LaVale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Markwood Funeral Home, Inc. P.O. Box 912, Keyser, WV 26726 23a. Part1. Enter the disease, or complication, that cause the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Squamous Cell Carcinoma of Call bladde 1/ months **Ehysician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 | Yes 2 No 3 | Probably 4 | Unknown ò 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Vas 210 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA edical Certification: To 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 To the Hospital of within 24 hours a To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier D58853 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 PENNSYLVANIA AVE., CUMBERLAND, MD 21502 HABIB CHOTANI,

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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		1	For State Registrar					ertificate of				Reg. No.	U U 4	166	48
			1. Decedent's Name	(First, Middle,							2. Date of Dea Month	ith Day	Year	3. Time of De	aath
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	Examin	C1	4a. Facility Name (If		_		T 1	4b. City, Town,			7		nty of Death	.14/	
	Europol		SAURED 5. Social Security Nu	HEAR mber	6. Sex	0 0 . /	1 A L n yrs. last birthday	) If Under 1 Year	If Under				- EGA	place (State or F	oreign
	Funeral Director		216-22-7		1 <b>X</b> M 2□1	7	7 Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Day MAY 19	,1926	FLOI	RIDA	
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	r 28a-	irect	10e. Street and Num	ber				10f. Zip Code				10g. Citizen o	of What Cou	ntry?	
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show the Madical Examirat must be notified at	Funeral Director	ROSSER	ROAD				267				U.S.	Α.		
	er dea	nue	11. Marital Status	3.5	Armed	ecedent Eve I Forces?	r in U.S. 13	l. Was Decedent of If Yes, specify Cub	Hispanic Or ban, Mexica	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14. F	lace - Ameri lack, White,		
36	irs aft	by F	1 Never Marrie 3 Widowed		If Yes,	es 2 □ No Give or Dates:	50-152	1 ☐ Yes 2 🔀 No	Specify:	:		Spe	city: W]	HITE	
21215-0036	72 hou	ted		15. Decedent	s Education t grade complete	ad)	16a. Dec	edent's Usual Occu	pation	t of working	ng	16b. Kind of	Business/In	dustry	
21	vithin ne.	Completed	Elementary/Secon		Coileg	e (1-4or 5+)	life.	DO NOT use retire	∍d)			TNSU	RANC:	E	
2	filed v Hygie other t		17. Father's Name (/	-irst, Middle, L	5+		V 1	CL-I KLD	· · · · · · · · · · · · · · · · · · ·		(First, Middle,				
Maryland	d d d	To Be		OPIE	ANNAN,	SR.			DOI	NELI	L DUNB	AR AV	IRET'	Γ	
ary	2 should and Men is marke sumstic	-	19a. Informant's Na	me/Relationsh	nip (Type, Print)		19b. Ma	iling Address (Stree	t and Numb	er or Rurai	Route Numbe	r, City or Tov	vn, State, Zip	Code)	
	1 and 2 Health sam 27 is		PEGGY AN		WIFE	1.	Page 100 100 100 100 100 100 100 100 100 10	. BOX 150	)7 –		ASHBY		6719		
Baltimore,	Pages 1 nent of H int: If ital		20a. Method of Disp	Cremation		om State	cemetery, ci	position (Name of rematory or other pla			(2004	20c. Locatio	-		
Ħ	urtmer artmer ortant injury		* 4 □ Donation  21. Signature of Fun		1		ROSE HIL	L CEMETER	ess of Facili	5/11/	URCH FUN ME7-P.		ERLANI ME, P.A		
Ba	permit. Departr Imports any inj		Amou	117	Tench	0110	,	<sup>22</sup> Name and Addr UPCHRCH 202 GREE	FUNER INE ST	AL-HO REET	CUMBE	A. RLAND,	MD 2	21502	
			23a. Part1. Enter the shock, or hear	disease, or	complications th	at caused the	death. Do not e							Approximate Interval Between	en
4	nysician		Immediate Cause (I	Final	. Co	an c	2 06 1	colon	undle	N		STRS	CS	Onset and Dea	ath
ſ	/Medical Examiner		resulting in death)	1	Due	to (or as a c	onsequence of):	0 0		0				6 1111	-
		ē	Sequentially list con	ditions. mediate	b. Due	to (or as a c	onsequence of):	24	al	Lu	u		-		
	uted d ansit	Examiner	if any, leading to impose to impose the cause. Enter Under Cause (Disease or inthat initiated events	lying njury	. 4	riefe	14 0	8 16.	M ( 0 .	1	PL	- dr	07		
o,	e be executed /sician and e burial-transit		resulting in death) L	ast	Due	to (or as a c	onseq ence of):				0		1		
8760,		dical			d.										
89 x	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:		23c. If ves.	outcome of p	pregnancy					234	Date of delive	any	
Вох	eath (	cian	23b. Was decedent in the past 12 r 1 Yes 2	months?	1 Li		Fetal death 3	Ectopic pregnanci	су				Month	Day Yea	àГ
Ö.	t the c by the tached	hys	9 Unknown		9□∪	nknown									
s, P	res tha igned be det	by P	Part II. Other signifi	cant conditio	ns contributing	to death but	ot resulting in the	underlying cause g	iven in Part	ا. خصر	_	_		he cause of deal	
ord	v require been sig should b	eted		ftes.	1017	-	-177	Other	>	004	1 🗆 Y	-		ably 4 🗆 Unk	
3ec	has b	Completed									24a. Was autop perfor		prior to co death?	psy findings ava mpletion of caus	allable se of
Vital Records,		e Co	25. Was case referr	ed to medical					26 Place	e of Death	1 ☐ Yes (Check only o		1 🗆 Yes	2 No	
Ž	S S D	o B	examiner?		Hospital:	✓ Inpatient	2 ER/Outpati	ent 3 DOA	ther		ne 5 Resid		Other (Specia	<i>y</i> )	
n of	ng Phys fter this neral di	on: T	27. Manner of Death	5 Pending	//	ate of Injury Month, Day Y	28b. Time lnjury	We	ork?		8d. Describe h	ow injury occ	urred		
sio	Attending r death. sctor: After by the fune	catl	2 ☐ Accident 3 ☐ Suicide	investig	not be	lana of Injuga	At home form		]Yes 2. □	-	29f Location /6	Street and Mu	mher or Dun	al Route Number	
Division	after of Dirac	Certification;	4 Homicide	determi	ined 286. P	uilding, etc. (	Specify)	street, factory, office	,	2	City or Tox		mber or nura	i noute Number	,
	To the Hospital or Attending Phwithin 24 hours after death.  To the Funaral Diractor: After thi completely filled in by the funeral.		29a. Certifier					ath occurred at the							
	the Ho in 24 the Fu	ledical	one)		and r	nanner stated	amination and/or d.	investigation, in my		ath occurre					
	To To To To To To To To To To To To To T	Σ	29b. Signature and	itle of certifier			0 6 7	29c. Licer	ise number	70	20	29d. Date sig	ned (Month,	H 9 x	-9.50
1	2/IVA		you !	1	y ug	un	h (ltem 22c) (T)	) V		1 >	0	101	110	100	7
_	W.DB nks		30. Name and address					ve i Cunt	perlan	nd N	10 21	502			
Ú	Sta		31. Date filed (Mont	h, Day, Year)	3	2. Registrar's	Signature					3 - 01			
	Registi	ar	W	Y 112	2004	men	10	Spark							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Physician 210 Am Lloyd Chester Bishop, Sr. 1172 May 2004 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 14439 Rice Road Hancock Washington 8. Date of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) PA Funeral Days 1**∑**M 2□ F Months Hours 216-38-1111 63 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Depertment of Health end Mentel Hygiene. Important: If item 27 is marked other then "netural", or frems 23a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2√2 No Funeral Director Washington Hancock 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14439 Rice Road 21750 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Yes 2 X No Specify: \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 11 Hauling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be ဥ Chester Bishop Isabelle Rav 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 14439 Rice Road Hancock, MD 21750 JoAnn Bishop/Wife 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn 05/14/04 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sonature of Funeral Service Licer 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or com-shock, or heart failure. List only blications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. hysician /Medical Immediate Cause (Final & month disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): attending physician Physician/Medical the Due to (or as a consequence of): es Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. the a 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No 3 Probably 4 Unknown \$ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy this certificate 1□ Yes 2☑No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? erel Director: After I filled in by the funera 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours a

To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

melana MD.

32. Regiştrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25

McCorneck

P41667

29d. Date signed (Month, Day, Yeer)

Medical Compos Dagerstan MO

State

Registrar

within 2 To the F

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Maryland / D	epartment of H Certificate of I		Reg.	ne No. 2004	16650
Physici /Medic		Decedent's Name (First, Middle, La     NANCY JEAN	BECK			MAY 1	<del></del>	3. Time of Death 5:40p
) Examir	ier	4a. Facility Name (If not institution, giv 22534 Hidden	Acres Lane	Rock			4c. County of Death  Kent	
Funeral Director		5. Social Security Number 6. S  218-24-3801  Usual Residence of Decedent	CH OFFE	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Apr 17	ar) Cour	lace (State or Foreign try) yland
Maryland f ehow	ior	10a. State 10b. County  MD Kent	10c. City, Town	or Location			1	0d. Inside City Limits 1 ☐ Yes 2 X No
vith the	Direc	10e. Street and Number		10f. Zip Code			Citizen of What Cour	ntry?
Within 72 hours after death with the Maryland within 72 hours after death with the Maryland ane.  than "naturel; or lieme 23s or 28s-f show than "naturel; or lieme 23s or 28s-f show is Medical Examinar usual be inclined a	by Funeral Director	22534 Hidden A  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1   Yes 2 MNo If Yes, Give Year or Dates:	2166  13. Was Decedent of H If Yes, specify Cuba  1 □ Yes 2 ☑ No	ispanic Origin? (Sp	ecity Yes or No-	S - A -  14. Race - Americ Black, White, Specify: Wh	
of within 72 hours all glene.  or than "naturel", or the Neutical Exam.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0·12)		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Homemaker	during most of work f)	ing 16b	Own Home	
Maryland A nd 2 should be filed tith and Mental Hygie 27 Is marked other traumatic event,	To Be Co	12 17. Father's Name (First, Middle, Last John Herdman			18. Mother's Nam	e (First, Middle, Maid m Louise		
partitions, individual XIXIS-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or iteme 23a or 28a-f show may injury or other traumatic event, the Medical Examinational be mailined at once.		19a. Informant's Name/Relationship ( Charles Beck  20a. Method of Disposition 1	(husband) P.  20b. Place of cemeter,	Mailing Address (Street. O. Box 20 Disposition (Name of or, crematory or other place) Cremation  22. Name and Addre	9 Rock	Hall, M Date 200	ID. 21661 Location - City or To	own, State
Physician // Medical per xe-uted by physician and by physician and as the burial-transit	dicai Examiner	23a. Part: Entif the disease, or composed to shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Squientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence of Due to (or as a consequence	Breat (	•			Interval Between Onsel and Death Onsel and Death Macmithis
death cert e attendin d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of delive Month	ery Day Year
S 5 8		. 1	contributing to death but not resulting in		en in Part I.	23e. Did tobace 1 ☐ Yes	co use contribute to the	ne cause of death?
	Completed by	,				24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to co	psy findings available mpletion of cause of 2 No
Attending Physicien: The refeath. sector: Atter this certificate by the funeral director, page 1997.	ition: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		ime of 28c. Injur	er: 4 Nursing H	th (Check only one) ome 5 X Residence 28d. Describe how i	e 6 Other (Specifing occurred	y)
	Certification:	3 Suicide 6 Could not 1 4 Homicide determined		rm, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	ll Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (		hysician: To the best of my knowledge miner: On the basis of examination and and manner stated.					
To ti withi To ti comp	W	29b. Signature and title of certifier	200	D SC	e number		Date signed (Month,	Day, Year)
5		30. Name and address of person who Neil Stoddar		Type, Print) rown St. (	Chestert	own, MD.	21620	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra Signature	D. Sparte				

¢		- State Registrar AMEND ITEM #24a	tate of Marylar PER VERB C831	id / Depa 5 <b>/25/9</b>	artment of H	ealth and Death	R	eg. No.	. 10001
Physici /Medi		Decedent's Name (First, Middle, Last)     James		Bell, S			2. Date of Dear	, 2004 Yee	3. Time of Death 0715 м
Examir	You	4a. Fecility Name (If not institution, give street 402 East Ninth Street Social Security Number 6. Sex		last birthday)	4b. City, Town, or Fre	Location of Deat derick If Under 24 Hrs			ederick irthplace (State or Foreign
Funeral Director			2□ F 77	Yrs.	Months Days	Hours Min.	8. Date of Birth Feb. 9ay	1927 Vii	ginia
Maryland a-f ehow	ctor	Maryland Frederick		y, Town or Lo edericl					10d. Inside City Limits  XXYes 2 □ No
th with the 23a or 28	Funeral Director	10e. Street and Number 402 East Ninth Str	eet		10f. Zip Code 21701			•S•A•	Country?
perfull Deciding yield a Line 100000 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itams 23a or 28a-f show any injury or other traumatic event. If a Modical Exacting retual be rediffed at ance.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 XYes 2 No If Yes, Give 1944-19 Year or Dates.	946	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes      ※ YWNo	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify: W	
in all y latter A. 12.15.0000000000000000000000000000000000	Be Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired; e Manager	uring most of wo	orking	16b. Kind of Busines News Age	
should be filed vand Mental Hygie marked other turnatic event. It	To Be Co	17. Father's Name (First, Middle, Last)  David Lee Be	<u></u>	1			me (First, Middle, I ia Mercha		
and 2 shou balth and M m 27 ie mar traumat		19a. Informant's Name/Relationship (Type Mrs. Belva L. Bell		19b. Mailir 402	ng Address <i>(Street a</i> East Nint	nd Number or R h St., I	ural Route Number Frederick	, City or Town, State , MD 2170:	Zip Code) 1
Definition of the parameter of the parament of the proportant: If item any injury or other page.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ren 1 4 ☐ Denation 5 ☐ Other (Specify)		cemetery, crer	sition (Name of matory or other place et Cemetery	May 1		20c. Location · City of Frederick	or Town, State , Maryland
permit. Departn Imports any inju		21 Signature of Funeral Service Licenseer  21 A C C C C C C C C C C C C C C C C C C	Res far Good	121	Name and Addres Keeney an 106 Fast	d Basfo	rd Funera	l Home	MP 21701
ifficate be executed /Medical Examiner as the burial-transit	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Neth	quence of):	e lu		ran ce		Inferval Between Onset and Death
death cerr e attendin od for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \triangle	If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of a 9 Unknown	aldeath 3⊑	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
juires that the signed by the detact		Part II. Dther significant conditions contri	buting to death but not re	sulting in the u	nderlying cause give	en in Part I.			to the cause of death?
Physician: The law requires that the rthis certificate has been signed by the rail director, page 2 should be detach	Completed						24a. Was a autops perform	med? prior to death	autopsy findings available o completion of cause of ?
sician: T certificate rector, pa	Be	25. Was case referred to medical examiner?	pital:		Otho		ath (Check only or	***	
Afte	tlon: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	4   Nursing	Home 5 Aeside 28d. Describe ho	ence 6 Other (Sp ow injury occurred	pecify)
Atten Atten ector: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str fy)	eet, lactory, office		281. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
Hospitel or 124 hours afte Funerel Dir letely filled in	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my kn r: On the basis of examin- and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	e, date and plac pinion, death occ	e, and due to the courred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	Sport	Hm.	29c. License			9d. Date signed (Mo	
		30. Name and address of perior who say	leted cause of death (Ite	т 23a) (Туре, ЗОС	Print)	7 H S	+ Fre	May 10	K MD
St. Regist	ate rar	31. Date liled (Month, Day, Year) MAY 2, 5, 2004	32. Registrar's Sign	audi ,	parks				

			Please Type or Print in Black Indelible Ink. Ensure All Copies are Legible.
			State of Maryland / Department of Health and Mental Hygiene  1- State Registrar Amend#17, perFH, FCHD, SL, Certificate of Death 5/12/04 Reg. No. 2004 1655
	Physici		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Pay Ph 2004 4:004. M
	/Medio Examir		4a. Facility Named (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  FREDERICK  4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 202F 7 (Yrs.   Months   Days   Hours   Min.   JAN. 25, 1928   Quitals Ann
	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	the Mar 28a-f st notified	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?
	s 23a or	erai Di	343 FIELDPRINT BLID APT. 10 21701 U.S.A.
5-0036	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show important: if item 27 is marked other than "naturel", or items 23a or 28a-f show hy injury or other traumatic event. In a Mcdigal Examinar must be notified at ODGs.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No Specify:  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 Yes 2 No Specify:  Specify: BLACK
215-0	n 72 h	Completed by	15. Decedent's Education (Specify only highest grade completed)  [Secondary (0-12)   College (1-4or 5+)  [Secondary (0-12)   College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working (iffe. DO NOT use retired)  [Iffe. Do NOT use retired)
21	filed within Hygiene. other than "		Elementary/Secondary (0-12) College (1-4or 5+) CuSTOdiAN Md. School DEAF  17. Father's Name (First, Middle, Last) Harry Son Paymer 18. Mother's Name (First, Middle, Maiden Surmame)
Maryland	should be ind Mental marked o	To Be	JAMES E. AMBUSH HANNIE OLNEY
77	1 and 2 sho Health and Iem 27 Is mu		19a. Informant's Name/Relationship (Type, Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code)  NANNIE THOMOSON  107 PROVIDENCE CT. FRED. MO. 21703
Baltimore,	Peges 1 and of He Int: If item Inty or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 PRICE CEPT.  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State
Balti	permit. Peg Department Important: b any injury o	1 9 1 10	21. Signature of Funeral Service Licentee 22. Name and Address of Facility GRAY - ROLLINS FULLERAL HORE 110W, South ST. FRED. MD. 21701
· ·	% <u>ş</u>	0	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final   Cause (Final ) C
	Physician /Medical Examiner		disease or condition resulting in death)  Due to (or as a consequence of):
	J. Cal	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Due to (or as a consequence of):  END CTAGE REDNAY DISEASE (LOGICS)
.09	be executed sicien and burial-transit	i Examiner	resulting in death) Last  Due to (or as a consequence of):
687		edicai	d. HYPENTEWYUW
P.O. Box	es that the death certificate tigned by the attending physic be detached for use as the E	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 21840 3 Probably 4 Unknown
Records,	e law req has beer e 2 shou	Completed	24a. Was an autopsy performed? death?
Vital F	ian: Thi rtificate tor. pag	0	25. Was case referred to medical  26. Place of Death (Check only one)
of V	hysic this ce	To B	examiner?  1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)
	nding Fath. r: After e funera	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury 28b. Time of Section of Injury 28b. Time of Section of Injury 32b. Time of Section of Injury at Work? 1 Yes 2 No
Division	• Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the	Me	29b. Signature and title of gentifier  29c. License number  29d. Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
- 2	Sta	ite_	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Regist		MAY 12 2004 Server & Spark

		-	For State of Hegistrar	Maryland / I	Departmer Certificat				giene Reg. No. 20 (	16653
			Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physicia	ın		. Sr.				Month May	Day Ye	12:30 A <sup>M</sup>
	/Medic		Paul Eugene Blake  4a. Facility Name (If not institution, give street and num		4b. City	Town, or	Location of De		4c. County of [	
	Examin	er			-	. 1	.11		Manta	
_			Shady Grove Adventist H 5. Social Security Number 6. Sex	OSD1tal '. Age (In yrs. last bi			<b>i 1 1 e</b> If Under 24 F	Irs. 8. Date of Birt	h Mont go	omery Birthplace (State or Foreign
	Funeral Director		207-30-0478	65	Yrs. Months	Days	Hours M	in. (Month, Da	y, / ou/	Country) Pennsylvania
		1	Usual Residence of Decedent					- OCC - 15	., 1930 1	
	yland		10a. State 10b. County	10c. City, Tov	wn or Location					10d. Inside City Limits
	Mar Mar	to	Maryland Montgomery	Dic	kerson					1 ☐ Yes 2X No
	7 288	Director	10e. Street and Number		- · · · · · · · · · · · · · · · · · · ·	p Code			10g. Citizen of Wha	t Country?
	3a o		7533 Banner Road			20	842		U.S.A	١.
	ms 2	Funeral	11 Marital Status 12. Was Deced	tent Ever in U.S.	13. Was Dece	dent of Hi	spanic Origin?	(Specify Yes or No lerto Rican, etc.)	- 14. Race -	American Indian, White, etc.
(0	r Ita	교	1 Never Married 2 Married 1 Yes	2 <b>X</b> No	1.20			iaito riican, atc.)		VIIIto, Ott.
03	urs a	ρχ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Da	tes:	1 🗆 Yes	ZINO	Specify:		Specify: V	White
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 20a or 20a-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Education	168	a. Decedent's Usu	al Occupa	ation furing most of	workina	16b. Kind of Busin	ess/Industry
215	within 7 ene. than "n	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	4or 5+)	(Give kind of w life. DO NOT	ise retired	)		Waterprod	ofing &
21;	filed withir Hygiene. other than ent, the M	Ю	11th		wner & C	pera	tor		Construct	ion
	e filed I Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle,	, Maiden Sumame)	
Maryland	12 should be fit h and Mental H 7 Is marked otl traumatic ever	To B	Marshall Wayne Blake				Mar	y E. Ki	tchen	
ary	s 1 and 2 should f Health and Men Item 27 Is marke other traumatic	_	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing Addres	s (Street a	and Number or	Rural Route Numb	er, City or Town, Sta	ite, Zip Code)
Ž	nd 2 lith a 27 is r tra		Joanne Marshburn - Careg	iver 7	533 Banr	er R	oad, Di	ckerson,	Maryland	20842
ē,	is 1 and 2 of Health Item 27 other tra		20a. Method of Disposition	anmat.	of Disposition (Na	ame of	e)	Date	20c. Location - Cit	y or Town, State
2	Pages nent of h int: if Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S  4 ☐ Donation 5 ☐ Other (Specify)	itate				5/11/04	Alexandri	la, Virginia
altimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Dicensee	·	22. Name a	ind Addres	s of Facility			
Ba	permit. Pages Department of Importent: if I any injury or once.		1 1 1/	inner					Funeral Ho	
			23a. Part1. Enter the disease, or complications that ca	used the death. Do	26401	Ridg	e Road, a. such as car	Damaset	<del>ıs, Maryla</del> rrest,	and 20872 Approximate
			shock, or heart failure. List only one cause on ea	ich line.				. ,		Interval Between Onset and Death
	Physician			iopulmona		ire				
	/Medical Examiner		Due to (	or as a consequence	e of):					
	LAdimie		Sequentially list conditions, b. Acut	e Renal F	ailure_					
	₽ ≒	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence	9 OI):					
	te be executed ysician and te burial-transit	Examiner	that initiated events c. ALCE	roscleros						
0,	e exe ian a urial-	ŭ	Due to (	or as a consequence	e or):					
1760,	<u>a</u> × <u>a</u>	cai	d							
68	ng ph as t	Physician/Med	IF FEMALE:							
Вох	h ce endii r use	an/	23b. Was decedent pregnant	come of pregnancy orth 2  Fetal deat	th 3 Ectopic	pregnancy			23d. Date of Month	
	deat e att	<u>ic</u>	in the past 12 months?  1 Yes 2 No  9 Unkno	ant at time of death	5 Other (s	specify)	,		,	buy rout
P.0	t the	hys	9 Unknown							
	The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the	y P	Part II. Other significant conditions contributing to de	ath but not resulting	in the underlying	cause giv	en in Part I.		_	ute to the cause of death?
rds	quire n sig uld b	be						_ 10	Yes 2 No 32	Probably 4 Unknown
Records,	w re	Completed by						24a. Was	an 24b. We	re autopsy findings available or to completion of cause of
Re	he la e has	m.						perfe	ormed? dea	ith?
a	n: T ficate or, pa	C	25. Was case referred to medical				26 Place of	Death (Check only	- 71	X
Vital	Physiclen: this certific ral director,	B	examiner? Hospital:	npatient 2 ER/C	Outpatient 3 0	Oth			idence 6 Other	(Specify)
of	Phys this ral di	-T			. Time of	28c. Injur			how injury occurred	
u	ding After fune	ion	Matural State and Ing	of Injury h, Day Year)	Injury M		k? Yes 2 □No			
Division	Attending r death. actor: After	Certification;	3 Suicide 6 Could not be ass Bloom	of Injury - At home,				28f. Location	Street and Number	or Rural Route Number,
Ξ	or Ai fter Jirec in by	rif	4 Homicide determined buildi	ng, etc. (Specify)	,,	.,,,		City or To	wn, State)	
	urs a	ပိ	29a. Certifier 1X Certifying Physicien: To the	hast of my knowled	Ine death occurs	d at the tir	ne date and n	lace and due to the	cause(s) and mann	er as stated
	Hosp 4 ho Fune ely fi	edical	(Check only 2 Medical Examiner: On the ba	asis of examination a	and/or investigation	on, in my o	pinion, death	occurred at the time,	date and place, and	d due to the cause(s)
	To the Hospitel or Attending Physiclen: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Med		ner stated.	2	9c. Licens	e number		29d, Date signed (	Month, Day, Year)
	To To	-	29b. Signature and title of certifier						MAY 9	
			Callys			V 3	3869		, , , ,	,/
	12		30. Name and address of person who completed caus						102	
	10		Richard A. Silva, M.I			Cente	r Dr.,	Rockville	e, Marylan	nd 20850
	Sta		Manager Compt. or the con-	egistrar's Signature	//-	1		, 1		
	Regist	rar	WAY 1 1 2004	Bayers	0	195	wells!			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Physician 7, Karen Doreen Brown May 2004 6:20 PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 105 Bishopstone Circle Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Months Days Min. 1 ☐ M 2 🖾 F Yrs. 219-70-6779 Director 45 June 23, 1958 Maryland Usual Residence of Decedent parmit. Pegas 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelih and Mertiel Hygiena. Important: If flem 27 is marked other than "natural" --- any injury or other treumatic executions. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 StYes 2 □ No Funeral Director Maryland Frederick Frederick 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 105 Bishopstone Circle 21702 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces:
1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates:1976 1979 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hote1 Night Auditor 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles A. Brown Mary V. Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mary V. Carlisle / Mother 105 Bishopstone Circle, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 8, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Resthaven Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 2004 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Juneral Service License 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 or lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed buniel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, for use es the Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Cacheria ð 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? ₽¥ No cartificate 1 L Yas 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this After this funaral of 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 44154 B-8-04 2. HEGAZI 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Frederich MD21702, A. 2. HEG-M2

State

Registrar

4-5

31. Date filed (Month, Day, Year)

B Thomas Johnson

32. Registrar's Signature

DV

			1 - State Registrar Amend#5,18,1	State of Maryla				SL,5/18/04	Reg. No.	004	166	6 5 <u>5</u>
	Physicia	an	Decedent's Name (First, Middle, Last)	LEN DUPONG I				2. Date of De Month April		2004	3. Time of 12:40	Death A M
>	/Medic		4a. Facility Name (If not institution, give st		DONGARD	4b. City, Town, or	Location of			ty of Death		
	Examin	er	College View Cente			Freder	ick		Fre	ederi	ck	
	Funeral Director		5. Social Security Number 6. Sex 132-01-3170 132-01	7. Age (In yi	s. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8. Date of Bir (Month, Date of Bir 20	th ly, Year) 1914	9. Birth Cou New	place (State of ntry) York	r Foreign
	Maryland f ahow	or	Usual Residence of Decedent  10a. State  10b. County  Maryland Frederic		City, Town or Lo				. 12		10d. Inside Cit 1₩Yes	•
	r 28a-	irect	10e. Street and Number		rederic	10f. Zip Code			10g. Citizen of	f What Cou	ntry?	***
	23a o	alD	700 Toll House A	venue		2170				5.A.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 🖫 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ì	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Ori n, Mexicar Specify:	gin? (Specify Yes or No n, Puerto Rican, etc.)	Spec	ace - Ameri ack, White, ify: WI		
21215-0036	vithin 72 ho ne. han "natur n Wedical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during mosi )	t of working	16b. Kind of	Business/Ir Home	ndustry	
22	Hygier Hygier ther ti	CO	17. Father's Name (First, Middle, Last)		1	Homemaker	18. Mothe	or's Name (First, Middle				· · · · · · · · · · · · · · · · · · ·
an	lental ked o	To Be	David Dupong				Bert	<del>ha Ferais</del>	Bertha	Ferri	.s	
Maryland	2 shou and N is mar		19a. Informant's Name/Relationship (Typ			-		er or Rural Route Numb				
	l and lealth om 27 her tr		-John Bongard (Son 20a. Method of Disposition	John W. Bongard, Jr		Greenswa	ard L	ink, Ijamsv	20c. Location			
nor	ages ant of th it: If ite y or of		1X Bunal 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei	matory or other placing Cemeter		5/13/04	Coldspi	-		rk
Baltimore,	permit. F Departmi Importar any injur		21. Signature of Funeral Service Liceose	Deler				Ý & SON FUN ET ST., FRE				
760,	Physician /Medical Examiner burial-Itansit s the burial-Itansit	cal Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure Liet only on the control of th	Due to (or as a cons	equence of):			cardiac or respiratory a			Approximate interval Better Onset and D	ween
O. Box 68	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of preg 1 Live birth 2 For 4 Pregnant at time o 9 Unknown	etel death 3	□Ectopic pregnancy □ Other (specify)				eate of deliv		'ear
ds, P	uires that n signed b Id be deta	þ	Part tl. Other significant conditions confi	nbuting to death but not r	esulting in the u	inderlying cause give	en in Part I.		tobacco use con Yes 2——™o		he cause of de bably 4 □U	
I Records,	The faw requirate has been sipage 2 should	Completed						24a. Was auto perfo		. Were auto prior to co death? 1  Yes	opsy findings a ompletion of ca	ivaliable iuse of
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe		of Death (Check only				
Division of Vital	ding Afte fune	tlon: To	27. Manner of Death  Valural 5 Pending investigation	28a. Date of Injury (Month, Day Year)		of 28c. Injury Work	NU		how injury occu		<u>(y)</u>	
Divis	el or Attenos s after death si Director: sd in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, sti cify)	reet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Run	al Route Numb	ber,
	To the Hospitel or Al within 24 hours after of To the Funerel Dirac completely filled in by	edical (		ician: To the best of my ker: On the basis of examinand manner stated.								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	C/1		29c. License			29d. Date sign	ed (Month,	Day, Year)	
,			1 paper	(. Nu	m is	77	5428		5/	5/04		
	6		30. Name and address of berson who cor Casper E. CLine,	npleted cause of death (It	em 23a (Type, 300 West	Print) 9th St.	Fred	erick, Md.	21701	/ /		
70	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig		15 A	oak.	2				

			For State		ryland / Dep			lental Hygi	ene 200L	16656
			1 - State Registrar Amend#1, per	MD, FCHD, SI	L,5/14/04 <sup>e</sup>	rtificate of	Death		g. No.	
	Physici	an	1. Decedent's Name (First, Middle, Las	" Mary Mere	edith Ford	Brown		2. Date of Death Month	Day Year	3. Time of Death
	/Medic			h Brown F	<del>ord </del>	45 City Taylor	or Location of Death	May 2,2		8:25 A M
	Examin	er	4a. Facility Name (If not institution, give						4c. County of Dea	
			Frederick Memoria 5, Social Security Number 6. Se		(In yrs. last birthday	Frederi If Under 1 Year		8. Date of Birth	Frederic	
	Funeral Director			<sup>□</sup> M <sup>2</sup> □F 6:	. ,	Months Days	Hours Min.	(Month, Day, 8-2-194)	Year) Co	thplace (State or Foreign buntry)
			Usual Residence of Decedent	Λ 0.			1	0-2-174	ı raı	yrand
	ylenc		10a. State 10b. County Md. Frederi	0.12	10c. City, Town or L					10d. Inside City Limits
	Mar 9-1-9	tor	Md. Frederi	CK	Frederic					1X Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	23a	aic	430 Carrollton D	rive		21701			U.S.A.	
	r des	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp ean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	or the	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give	0	1 ☐ Yes 2 <b>X</b> No	Specify:		Specify: Whi	te
Ö	tural al Ex	b d	15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual Occur	nation		6b. Kind of Business	/Industry
Ċ	In 72	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of work	ding '	ob. National Desiriosa	maastry
7	that iene.	m <sub>o</sub>	Elementary/Secondary (0-12) 10 years	College (1-4or 5-	Wait	ress/Cas	hier		Food Indus	stry
0	Hyg othe	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
Maryland 21215-0036	lid be ked ked	To B	Raymond Harold F	ord, Sr.			Kathle	en Helen	Sease	
ary	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. ie marked other than "natural", or Itema 23a or 28e-f ehow aumatic event, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mail	ng Address (Street	and Number or Aur	ral Route Number,	City or Town, State,	Zip Code)
Ž	alth a		Debbie Winpigler		430 (	Carrollto	n Dr. Fre	derick. 1	Md. 21701	
ē.	item item		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ice)		Oc. Location - City or	Town, State
Ĕ	Page nent nt: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify				ory 5-7-	04 St	mithsburg,	Md.
Baltimore,	permit. Pages 1 end 2 should be Depertment of Health and Menta Important: if item 27 is marked any injury or other traumatic e <u>pnce</u> .		21. Signature of Juneral Service Light	See On		2. Name and Addre	ess of Facility DAILEY &	SON, FUN	ERAL HOMES	S, P.A.
	20 = e o		sonest.	1 aller	1	201 N. M	arket Str	eet Fred	erick, Md.	21701
			23a. Part 1. Enter the disease, or com- shock, or hear failure. List only	one cause on each line	the death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arres	St,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	YOCar	ligh	Intar	CLION		hours
	/Medical Examiner		1000king in dodairy	Due to (or as a	consequence of):					
		-	Sequentially list conditions,	b. Due to (or as a	consequence of:					
	insit	m L	Sequentially list conditions, if any, leading to infine diale cause. Enter Underlying Cause (Disease or injury							
Ć,	The law requires that the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
8760,	se be	dicai		d						
9	tifica ig ph as th	led								
ŏ	eath certific attending p	In/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		⊒Ectopic pregnanc	·v		23d. Date of de	
	the att	Physician/Me	in the past 12 months? 1  Yes 2 No	4 Pregnant at 1		Other (specify)	'7		Month	Day Year
Р. О.	thet the di ed by the detached	hy	9 Unknown							
ŝ	es the igned be del	by (	Part II. Other significant conditions of	ontributing to death bu	0		ven in Part I.		acco use contribute to	
ord	w require been signated should b	ted	Coronary	ALLE		16016		1 Yes	s 2 No 3 P	robably 4 🖫 Onknown
ecc	hes be	Completed						24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
<u> </u>		Con						perform 1 Yes 2-	ed? death?	
/ita	Physician: The riths certificate he ral director, page	Be (	25. Was case referred to medical examiner?					th (Check only one	2	
<u>&gt;</u>	Physic this o	P	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier		III JUON			nce 6 Other (Spe	ecify)
ū	Ing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wo	ork?	28d. Describe how	w injury occurred	
20	deeth.	cat	2 Accident investigation 3 Suicide 6 Could not be	a -	n. At home form of		]Yes 2 □No	29f Location /Sta	eet and Number or R	umi Pouto Alumbas
Division of Vital Records,	after after Direction by	Certification:	4 Homicide determined	building, etc	ry - At home, farm, si . (Specify)	reet, factory, office		City or Town,		arar rodie reamber,
_	spitel ours nerai filled		29a, Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge, dea	th occurred at the t	ime, date and place.	and due to the car	use(s) and manner a	s stated.
	To the Hospitel or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Medical		niner: On the basis of and manner stat	examination and/or is					
	To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mon	th, Day, Year)
			Jacob	(Isux	ier My	). D	4)621	2-	404	
	10		30. Name and address of person who	1)	٥.	×	in has	m els	16. 317	103
	Sta	te	31. Date filod (Month, Day, Year)	32. Registra	r's Signature	Ce	4	10.0	C. C.	
	Regist		MAY 1	4 2004	Depera	D S	souls!			

Discontinuo		Registrar		Ce	rtificate of I	Death		eg. No.	01	1000
Physician /Medical		Decedent's Name (First, Middle, Las	OARD				2. Date of Dear Month May	Day 200	Year	time of Openin LO:15 A
Examiner	à	a. Facility Name (If not institution, give Herrington Harbor	Marina			eale			of Death  Arunc	lel
uneral irector		. Social Security Number 6. Sec. 17  041-50-3195  Usual Residence of Decedent	ex 7. Age	(In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthplace Country)	(State or Foreig
be notified at	1	Oa. State 10b. County  MD QUEEN A	NNE'S	10c. City, Town or Lo						nside City Limits
23a or 28a-f s ust be notified af Director	1	Oe. Street and Number 732 CLOVERFIELDS	DR.		10f. Zip Code <b>21666</b>		1	0g. Citizen of W	hat Country?	
tems wr.m		1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent   Armed Forces?   1  Yes 2  If Yes, Give   Year or Dates:	No i	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 █ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American In , White, etc. WHIT	
If item 27 is marked other than "natural, or i or other traumatic event, the Medical Exant. To Be Completed by Fi		15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	de completed) College (1-4or 5	ife.	dent's Usual Occupa kind of work done of DO NOT use retired	)		16b. Kind of Bus		y
arked oth atic even To Be	1	7. Father's Name (First, Middle, Last)  GEORGE BEDARD					ne (First, Middle, A L <b>E GREENO</b>		)	
27 is ma r trauma	1	9a. Informant's Name/Relationship (T) <b>DEBRA LEE BEDARD</b>			g Address (Street a					1666
Important: If item 27 is marked other than any injury or other traumatic event, the Me once.  To Be Compl	_	0a. Method of Disposition  1 X Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,	Removal from State	20b. Place of Dispo	sition (Name of natory or other place	a)	Date 2	Oc. Location - C	ity or Town, S	State
Importa any inju once.	2	11. Signature of Experience Licens	191C	r FE	Name and Address LLOWS, HE	s of Facility	I & NEWNA	M FUNER	AL HOMI	
physician and subspice sthe buriat-transit abundant subspice and subspice s	5	ilsease or condition esulting in death)  lequentially list conditions, any, leading to immissionate ause. Enter Underlying Jause (Disease or injury	Due to (or as a	a consequence of):	ATHEROS	CLEROTIC	DISE	A SE	AR	
	,,	rause (Disease or injury nat initiated events esulting in death) Last	c. Due to (or as a	a consequence of):						
0 6 0		nat initiated events assulting in death) Last	c. Due to (or as a d.  23c. If yes, outcome of the pregnant at the second of the secon	of pregnancy 2	Ectopic pregnancy Other (specify)			23d. Date Montl		Year
igned by the attending be detached for use as by Physician/Me	1F 2:	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1   Yes   2   No	d. 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	of pregnancy 2	Other (specify)	n in Part I.			n Day	se of death?
cate has been signed by the attending page 2 should be detached for use as Completed by Physician/Me	Pæ	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown art II. Other significant conditions con	d. 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	of pregnancy 2	Other (specify)	n in Part I.		Month acco use contrib a 2 \( \text{No} \) 3 24b. We prived?	n Day ute to the cau □ Probably	se of death?  4 Ahknown  Idings available on of cause of
this certificate has been signed by the attending at director, page 2 should be detached for use as To Be Completed by Physician/Me	Par 255	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown art II. Other significant conditions cond	d.  23c. If yes, outcome of the properties of th	of pregnancy 2	Other (specify)  derlying cause given  3 □ DOA Other	26. Place of Deal	1 Yes  24a. Was an autopsy perform 1 XX es 2 1  h (Check only one ome 5   Residen	Month acco use contrib a 2 No 3 24b. We prive december 10 3 cce 6XXXIII	ute to the cau Probably pere autopsy fin or to completic ath? Nes 2 \( \) N	se of death?  4
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oral Director: After this certificate has been signed by the attending tilled in by the tuneral director, page 2 should be detached for use as I Certification; To Be Completed by Physician/Me	Pa 25	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  art II. Other significant conditions con	d.  23c. If yes, outcome of the property of th	of pregnancy 2   Fetal death 3   time of death 5   it not resulting in the un  at 2   ER/Outpatient y Year)   28b. Time of Injury ry - At home, farm, stre. (Specify)  f my knowledge, death examination and/or inv.	Other (specify)  derlying cause gives  3 DOA Other  28c. Injury. Work' M 1 Y et, factory, office	26. Place of Deat  4 \( \tag{\text{Nursing Ho}}\)  at  9s 2 \( \text{No}\)	24a. Was an autopsy perform 1 To See 2 1 h (Check only one ome 5 To Residen 28d. Describe how 28f. Location (Stre City or Town,	Month  acco use contrib  a 2 No 3  24b. We prive dec 12  No 12  Oce 6 Other vinjury occurred vinjury occurre	ute to the cau Probably  Pre autopsy fin or to completic ath?  (Specify)  Sor Rural Route	se of death?  4 Donknown  Idings available on of cause of the second of cause of cause of the second of cause of the second of cause of
ral Director: After this certificate has been signed by the attending lied in by the tuneral director, page 2 should be detached for use as Certification; To Be Completed by Physician/Me	Pa 25	FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  art II. Other significant conditions con	d.  23c. If yes, outcome of a control of the pregnant at the second of the pregnant at the pre	of pregnancy 2   Fetal death 3   time of death 5   it not resulting in the un  at 2   ER/Outpatient y Year)   28b. Time of Injury ry - At home, farm, stre. (Specify)  f my knowledge, death examination and/or inv.	Other (specify)  derlying cause gives  3 DOA  28c. Injury Work' M 1 Y et, factory, office  occurred at the time astigation, in my opi	26. Place of Deat  4 \( \) Nursing Ho  at  es 2 \( \) No  e, date and place, nion, death occur	24a. Was an autopsy perform 1 (24x) es 2    h (Check only one ome 5   Residen 28d. Describe how 28f. Location (Stre City or Town, and due to the caured at the time, dat	Month  acco use contrib  a 2 No 3  24b. We prive dec 12  No 12  Oce 6 Other vinjury occurred vinjury occurre	ute to the cau Probably  Probably  Probably  Profes 2 N  (Specify)  Or Rural Route  er as stated. d due to the ca	se of death?  4 Denknown  Idings available on of cause of to  SCENE  e Number,  ause(s)

			1 - State Registrar amend#10b	State of Mary perFH,FCHD,s1					Mental Hy	0.0	004	1665
	Physic	ian	Decedent's Name (First, Middle,	,					2. Date of D Month	Day	Year	3. Time of Death
1	/Medi		Lawrence Frankl						May		2004	8:00A M
	Exami	ner	4a. Facility Name (If not institution, s 401 West Potoma				own, or Lo .nswic	cation of Deat	h		y of Death deric	1-
	Funeral				yrs. last birthday)			Under 24 Hrs	8. Date of B		_	K. place (State or Foreig
	Director		218-34-3672	4 EP 14 0 C E	7 Yrs.		Days F	Hours Min.	8. Date of B (Month, D Sept	22 1936	Cour	nswick, MD
	and w		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation						04 1-14-05-11-1
	Maryla f sho	ō	MD Fredei	ck-	Brunswi							1 ☑ Yes 2 ☐ No
	28a	rect	10e. Street and Number	Frederick		10f. Zip C	ode			10g. Citizen of	What Cour	
	h with	Funeral Director	401 West Potoma	c Street			2171	16		US		,
	ems ems	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deceder	nt of Hispa	anic Origin? (S	pecify Yes or N o Rican, etc.)	o- 14. Ra	ce - Americ	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Evantries must be invitilled at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ∏XYes 2 ∏ No.		1 ☐ Yes 25		Specify:	o rican, etc.)	Specif	ick, White, fy: Wh	aite
5-0	72 h	Completed	15. Decedent's (Specify only highest)		16a. Dece (Give	dent's Usual (	Occupation done durin	n ng most of wo	king	16b. Kind of B	lusiness/In	dustry
121	within ene. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT us</i> e 1 <b>f –</b> Empi				Painter	and	Cab Drive
	filed Hygid Sther ent, II	a	17. Father's Name (First, Middle, La	st)	De	rr-rmp.			ne (First, Middle	, Maiden Surnar	ne)	
Maryland	should be find Mental I	To B	William Conner					Marie				
lany	2 shou and A is ma	·	19a. Informant's Name/Relationship							oer, City or Town		
	and lealth m 27 her tr	1	Beverly Frye, N					nac Str		unswick,	MD 2	21716
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If item: any injury or other once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Content of the Content		b. Place of Dispo cemetery, crea Resthave			Garden	Date s 5/11/	20c. Location		
Balt	permit. Departr Importr any inji		21. Sig/at 101 Final Service (Constitution of Final Service (C		22	2. Name and	Address of	f Facility		Home unswick,		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the o	leath. Do not ent	er the mode of	of dying, si	uch as cardiad	or respiratory a	rrest,	MD 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acint	Myr	cardi	1 .	Tinfo	chain			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):			TO VITA	70(100			5 minuso
В	Examiner		Sequentially list conditions,		10 schoot	L Vas	cular	Discour u	rik Hy	pertens	וטק	10 years
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):				(			
	execunate and al-train	Examiner	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):							
8760,	ate be executed hysician and the burial-transit	cail		d								
9	ntifical ng phy as th	ledi	IEEE VALE									
P.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregr Other (speci					te of delive onth	ry Day Year
	res that igned b be deta	by Pi	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying caus	se given in	Part I.	23e. Did 1	obacco use cont	ribute to th	e cause of death?
ğ	en sig								10	Yes 2□No	3 Proba	abiy 4 🗆 Unknown
Vital Records,	The law requate has been page 2 shoul	Completed								ormed?	prior to con death?	osy findings available apletion of cause of
ita		Be C	25. Was case referred to medical				26.	. Place of Dea	1 ☐ Yes		1 🔲 Yes	2LJ No
<u>&gt;</u>	Physician: this certifica ral director, p	2	examiner? 1 🗆 Yes 2 📉 No		2 ☐ ER/Outpatien	t 3□ DOA	Other: 4	□ Nursing H	ome 5 X Resi	dence 6 □Oth	er (Specity	)
o u	ing Ph Viter th uneral	on:	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c.	Injury at Work?		28d. Describe	how injury occurr	ed	
Sio	Attending ir death. ector: After by the fune	cat	2 Accident investigate 3 Suicide 6 Could not	ho		М		2 🗆 No				
Division of	itel or A irs after rel Direc led in by	Certification:	4 Homicide determine	building, etc. (Sp.	əcify)				City or To			
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 A Certifying F (Check only one)	Physicien: To the best of my aminer: On the basis of examand manner stated.	knowledge, death iination and/or inv	occurred at to estigation, in	he time, d my opinio	late and place n, death occu	and due to the red at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
,	To t To t	Σ	29b. Signature and title or confier.	and MD		29c. Li	Cense nur	ZO7	7	29d. Date signed		
	4+1		30. Name and address of person wh	o completed cause of death (	Item 23a) (Type, I	Print)	A): A	on A	. U =	Bau	vialli	2004
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	/	1000	111	1	- 11.00	-3000	
	Registr		MAY 1 (	2004 Sens	no p	1 4	0001	al .				
DUI	MH 17 Rev 1/20	201			•							

			1 - For State Registrar	State of Marylar				Mental Hyg	00	04 16660
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Las     John Lester Campbe     4a. Facility Name (If not institution, give	· 	-	4h City Town	or Location of Deat	2. Date of Deat Month	Bay 4c. County	Year 3. Time of Death  Year 4000 M
	Funeral Director	ier	Sacred Heart  5. Social Security Number 6. Se	Hospital	last birthday) Yrs.	( )	erland  If Under 24 Hrs  Hours Min.		A\\(\(\cent{\chi}\)	9. Birthplace (State or Foreign Country)  Maryland
	Ra-f show	Director	Usual Residence of Decedent           10a. State         10b. County           Maryland         Allegan		y, Town or Lo	cation			730	10d. Inside City Limits 1
	th with to 23a or 2 set be n	ai Dire	10e. Street and Number 14351SCE	enic View Street, S	.W.	10f. Zip Code 21502-			og. Citizen of W	What Country?
9000	hours after death with the Maryland turst; or Items 23a or 28a-f show at Examinar must be notified at	d by Funeral I	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1457-			lispanic Origin? (S an, Mexican, Puerl Specify:		14. Race Blac Specify	e - American Indian, k, White, etc. : <b>White</b>
21215-0036	J within 72 hours jiene. r than "natural"; Ine Modies Ex	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done OO NOT use retire	durina most of wor	rking	16b. Kind of Bu	siness/Industry
and 21	be filed stal Hyg od othe event,	Be	12 0 17. Father's Name (First, Middle, Last)		labore	r		ne (First, Middle, A		al construction
Maryland	2 should by and Menta is marked sumatic e	T <sub>o</sub>	Paul B. Campbell  19a. Informant's Name/Relationship (T)	ype, Print)				<b>VN</b> Iral Route Number,	City or Town,	State, Zip Code)
- 10	Pages 1 and 2 should nent of Health and Mer. nt: if item 27 ia marke iry or other traumatic			Removal from State	lace of Dispos	connecticut / sition (Name of patory or other place	Cres	Date 2	Marylo 20c. Location -	City or Town, State
Baltimore	permit. Pages 1 a Department of Hes Important: if item any njury or otha		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Euneral Service License	Cum		Name and Addre	ss of Facility	ost Ave., Fro		nd Maryland
8760,	death certificate be executed  radio and burial-transit  radio use as the burial-transit	Ilcal Examiner	23a. Part1. Enter the disease, or composhock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	n. Do not enter  Novascruence of):  Lerebruence of):	ular Ac				Approximate Interval Between Onset and Death 3 DAYS 3 DAYS 3 DAYS
P.O. Box 6	that the death certificated by the attending placed by the attending placed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year
	sigr sigr d be	by	Part II. Other significant conditions co	ntributing to death but not rest	ulting in the un	derlying cause giv	en in Part I.			bute to the cause of death?  3 Probably 4 Unknown
al Records,	ilcian: The law requ certificate has been rector, page 2 should	Completed						24a. Was an autopsy perform	ed? de	/ere autopsy findings available rior to completion of cause of eath? □ Yes 2 □ No
Division of Vital	Phys this al dii	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun World	er: 4 ☐ Nursing H	th (Check only one ome 5  Resider 28d. Describe how	nce 6 Othe	
Divis	To the Hospital or Attanding I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Numbe State)	r or Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, da	use(s) and man te and place, ar	ner as stated. nd due to the cause(s)
	D/IVA	Me	29b. Signature and title of certifier			29c. Licenso		29	_	(Month, Day, Year)
,	Sta Registr	te	30. Name and address of person who con Dr. Uriel Velar 31. Dates and thomps, Day Year 1		etan 1		oite #	303. Cu		nd MD 21502

nc:	_	est	er Contee Please				delible Ink. En				_			
_			1 - For State Ragistrar		aryland /		artment of Health tificate of Deal		ental H		ne vo2004	1666		
	Physic	ian	1. Decedent's Name (First, Middle, Las		<b>G</b>				2. Date of D Month		Day Year	3. Time of Death		
	/Medi	cal	-	vester	Cor	ntee			May 9			0215 P. N		
	Exami	ner	4a. Fecility Name (If not institution, give 12202 Fenno Road	street and number)			4b. City, Town, or Location			4	4c. County of Death			
			5. Social Security Number 6. Se	7 Age	θ (În yrs. last	hirthday)	Upper Marl		8. Date of B	lieth	Prince G			
	Funeral Director			<b>X</b> M 2□F	60	Yrs.	Months Days Hour	rs Min.	(Month, E	Day, Yea	1944 Was	pplace (State or Foreig intry) hington • DC		
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation		-			10d, Inside City Limits		
	Mary -f sh	ξ	Maryland Prince Ge	orges	Uppe:	r Mar	lboro					1 Yes 2 □ No		
	r 28a	rec	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Co	untry?		
	h with	Funeral Director	12202 Fenno Road				20772				USA			
	deat	ner	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. V	Vas Decedent of Hispanic Yes, specify Cuban, Mexi	Origin? (Spec	ify Yes or N	10-	14. Race - Amer			
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Exactinar man be norified at	Þ.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	Armed Forces? 1 ☐ Yes 2 ② tf Yes, Give Year or Dates:	No	1	Yes, specify Cuban, Mexi		ican, etc.)		Specify: B1	, etc. .ack		
ŏ	2 hou	ted	15. Decedent's Ed	ucation	10	6a. Deced	ent's Usual Occupation			16b.	Kind of Business/I			
218	thin 7 9.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(+)	life. [	kind of work done during r OO NOT use retired)	nost of working	g	Por	ard of Ed	hastion		
2	ed wil	Completed	12			Cust	odian			ВО	ard or Ec			
Maryland	nould be filed will f Mental Hygien narked other th	Be	17. Father's Name (First, Middle, Last)	TT	C	ontee		other's Name	(First, Middl	e, Maide				
<u> </u>	d Mer nark	ပ	Francis  19a. Informant's Name/Relationship (7	H				orence	G		Fleet			
S	d 2 sho th and t7 Is mu traum	4 3	Robert W. Contee/E				g Address (Street and Num Dairymaid Di							
<u>ئ</u>	Health Health tem 27		20a. Method of Disposition				sition (Name of patory or other place)	Da			Location - City or T			
9	ages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	Resu	rrect	cion Cemetery	v 5/14/	04		nton, Mary			
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		21. Signature of Funeral Service Licensee 22. Name and Address of Facility											
ä	Department of the population o		) Odessa Q	fer	MO13		dams Funeral		P.A. A	quas	sco, Maryl	and		
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or companies, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading or uninequals.	a. Tueste  Duello (or as a	a consequence	ce of):	erios clorest				or Dise	Approximate Interval Between Onset and Death		
	nsit	ri L	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury											
Ć,	e executed sian and urial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	a consequenc	e of):								
68760,	e be /sicial			d										
68	tificat ig phy as th	ledi		<b>.</b>										
O. Box	res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 1 □ Live birth 2 □ Pregnant at 9 □ Unknown	2 Fetat dea		Ectopic pregnancy Other (specify)				23d. Date of deliv Month	ery Day Year		
Δ.	that led by deta	-P	Part II. Other significent conditions co	ntributing to death bu	ıt not resulting	g in the un	derlying cause given in Pa	ırt I.	23e. Did	tobacco	use contribute to	he cause of death?		
sp.		p p	Emphysli	mai					1 🗆	Yes	No 3□Pro	bably 4 Unknown		
Ö	> 0 70	lete							24a. Was	san	24h Were aut	opsy findings available		
Records,	9 4 9	Completed							auto	opsy ormed?	prior to co	impletion of cause of		
ta	ician: Th certificate ector. pag	0	25. Was case referred to medical				26 Pla	ace of Death	Che on	2 🗆 N	lo 1 Yes	2 No		
<b>V</b>	d is	To B	examiner? <b>½∑</b> yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/	Outpatient	Othor				6 ☐Other (Speci	fv)		
o uc			27. Manner of Death  Satural 5 Pending	28a. Date of tnjun (Month, Day	y Year) 28b	Time of Intury	28c. Injury at Work?	28			ury occurred	,,		
Division of Vital	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Inju building, etc	ıry - At home, . (Specify)	farm, stre	M 1 ☐ Yes 2 et, factory, office		f. Location City or To	(Street a	and Number or Run te)	al Route Number,		
	ospital hours a uneral E		29a. Certifier 1 ☐ Certifying Phy (Check only 2 A Medical Exam	sicien: To the best o	f my knowled	ge, death	occurred at the time, date	and place, an	d due to the	cause(	s) and manner as s	tated.		
	ths H in 24 ths Fu pletel	Medical	one) 2[2-Medical Exam	ner: On the basis of and manner stat	ted.	and/or inv	estigation, in my opinion, d	eath occurred	at the time	, date ar	nd place, and due t	o the cause(s)		
)	To t with To t	Σ	29b. Signature and title of certifier	MD			29c. License numbe OCME	or			ate signed (Month, y 10, 200			

State

Registrar

MAY 1 3 2004

person who completed cause of death (tiem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

			1- For State of Maryland / Department of Health a Certificate of Death	and Mental F		2
	e.	si,	Decedent's Name (First, Middle, Last)	2. Date of Month		_
	Physici /Medic		Catherine A. Dohm	05	Day Year 9:40 AA	A
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	of Death	4c. County of Death	
	Funeral		SACRED MEART MOSPITAL CUMBER F  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under	r 24 Hrs. 8. Date of	Birth 9 Birthplace (State or Foreign	202
	Director		217-10-5999 1 M 2 F 89 Yrs. Months Days Hours	Min. (Month, Sep	Birth Day, Year)  9. Birthplace (State or Foreign Country)  10. 1914  MD	11 1
	w w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits	_
	Maryl. f sho	ţō	MD Allegany Cumberland		1 Q Yes 2 □ No	
	h the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?	_
	23a c		19 W. Roberts Street 21502		USA	
980	be filed within 72 hours after death with the Maryland that hygiene. id other than "natural", or items 23e or 28e-f show event, the Medical Everties must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 Yes, Give Year or Dates:		No-  14. Race - American Indian, Black, White, etc.  Specify: White	
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mos	st of working	16b. Kind of Business/Industry	_
121	e filed within at Hygiene. other then "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	•	Toytile	
d 2	filed Hygin othar ent,	Be Co		ner's Name (First, Mid	Textile  Idle, Maiden Surname)	_
Maryland 21215-0036	should be ind Mental markad o umatic eve	To B	William Anderson  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number		n) Anderson	
Ma	and 2 state at 127 ls		Darlene Eisentrout daughter 116 Jackson Street		mberland MD 21502	
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State	
Baltimore,	Pages ment of I	1	'4 Donation 5 Other (Specify) Sunset Memorial Park	5/13/20	Carriboriana MD	
Ball	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marka any injury or other traumatic once.	IJ	21. Signature of Funeral Service Licensee	eral Home, PA	Α	
	5255		23a. Parti Enter the disease, or complice flors that caused the death. Do not enter the mode of dying, such as shock or heart failure. List only one cause on each line.	venue: Cumb s cardiac or respirator	perland, MD 21502 y arrest, Approximate	
100	Physician		Immediate Cause (Final disease or condition		Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	a co	in le	_
	Examine:	7	Sequentially list conditions, fl any, leading to immediate  b. Due to (or as a consequence of )/		48 4.	-
$\mathcal{F}$	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  B. Due to (or as a consequence of)  Cat Repeal Carree no many that initiated events  C.	un col	breast elm.	
٦	rate be executed hysician and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):			
8760	icate be executed physician and s the burial-transit	dical	d			
9 xo	attending p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			_
$\mathbf{m}$	death atten	Physician/Me	23b. Was decedent pregnant in the past 12 movfths?  1  Yes 2 No 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery  Month Day Year	
Ö.	at the de by the tached	hys	9 □ Unknown 9□ Unknown			
Records, P.	es the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		id tobacco use contribute to the cause of death? □ Yes 2 □ No 3 □ Probably 4 □Unknown	I
ecc	e law requ has been je 2 shoul	Completed		24a. W	fas an 24b. Were autopsy findings available prior to completion of cause of	)
		Con			orformed? death?	
Vital	Physician: The this certificate ral director, pag	Be	examiner?	e of Death Check onl		
ō	ding Phys h. After this funeral di	1; To	1 Yes 2 4 Nu  27. Manner of Death 1 Anner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?		esidence 6 Other (Specify) be how injury occurred	_
<u>o</u>	ath. r: Afte e fun	ation	1 ☑★atural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ I	No		
Division of	l or Attand after death Director: /	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or 1	n (Street and Number or Rural Route Number, Town, State)	
	pital or urs afte aral Dir					
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral.	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	nd place, and due to the time at the time.	he cause(s) and manner as stated.  e, date and place, and due to the cause(s)	
	To t Com	Σ	29b. Signature and title of certifier 29c. License number	~ ~	29d. Date signed (Month, Day, Year)	
)	1	-	Maneger DO 83	. //	5-10.00	
	り		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Uniel Velandia, 902 SETON DRIVE, SUITE # 36	-2 0	20210 644 614 103	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	os: Cowre	EKTUND WID 91209	_
	Registra	ar	MAY 2 5 2004 > Regue & Goods			

			State of Maryland / Dep 1- State Registrar Amend#8, perFH, FCHD, SL, 5/17/04e	artment of Health and Menta rtificate of Death	ral Hygiene
	Physicia		1. Decedent's Name (First, Middle, Last)  Thomas G. Dwyer	2. Da	ate of Death South Pay Sear Ay 13, 2004 12:10 P
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) 2482 Five Shillings Rd.	4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday 71 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Da   Months   Days   Hours   Min.   (Mo	ate of Birth Month, Day, Year)  -24-1933  9. Birthplace (State or Foreign Country)  Maryland
	Maryland a-f show	tor	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or L           Maryland         Frederick         Fred		
	with the 3a or 28 If be not	I Director	10e. Street and Number 2482 Five Shillings Rd.	10f. Zlp Code 21701	10g. Citizen of What Country? United States
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show avent, the Madical Examiner must be notified at	by Funeral		Was Decedent of Hispanic Origin? (Specify Y. If Yes, specify Cuban, Mexican, Puerto Rican, 1  Yes XXNo Specify:	/es or No- , etc.)  14. Race · American Indian, Black, White, etc.  Specify: White
21215-0036	filed within 72 hou Hygiene. other than "natura ent, the W. cical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1·4or 5+)	ident's Usual Occupation e kind of work done during most of working DO NOT use retired) timater	16b. Kind of Business/Industry  Construction
land 2	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) William Edward Dwyer		it, Middle, Maiden Sumame)
Maryland	<b>₽ £ № ₽</b>			ing Address (Street and Number or Rural Route Five Shillings Rd. F	
Baltimore,	e = = 5	ĺ	20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition Cametery, cree  Cate of	osition (Name of matory or other place) Heaven 5-17-04	20c. Location - City or Town, State Silver Spring, Maryland
Balti	permit. Pa Departmen Important: any injury once.		ountrul Mathis 1	2. Name and Address of Facility Stauff 621 Opossumtown Pike	Frederick, MD 21702
8760,	whysician and whysician and whysician and whysician and the burial-transit	cal Examiner	23a (Part 1. Enfer the disease) or complications that caused the death. Do not enter the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Smull cell	Sand Death 4 WEEL
Box 6	eath certific attending p for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ords, P.O.	requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
of Vital Records,		Completed		1[	24a. Was an autopsy performed?  ☐ Yes 2 No   24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No   1 ☐ Yes 2 ☐ No
f Vit	Physician: this certifical	To Be	25. Was case referred to medical examiner?  1   Yes   2   Hospital: 1   Inpatient   2   ER/Outpatie		5 Nesidence 6 Other (Specify)
Division c	fe fe	Certification:	27. Manner of Death  1 Natural	Work?   M	Describe how injury occurred  ocation (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier (Check only one)  One)  Certifying Physician: To the best of my knowledge, dear of the basis of examination and/or in and manner stated.		
•	To the within To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
/	10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)  350 F-edeal	May 13,2004
	Sta Regist		31. Date filed (Month, Day, Year) 1 4 2004	& sporker	

			For State Registrar	State of Ma	aryland / Depa	artment of He rtificate of D	eath	Reg. N	C 0 0 4	16664
			1. Decedent's Name (First, Middle	, Last)			2.	Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic Examin	al	Eleanora 4a. Facility Neme (If not institution	L., give street and number)	Dolman	4b. City, Town, or L			004 c. County of Death	4:52 A M
	Lxaiiiii	CI	100 Burgess Hil	1 Wav Apt.	211	Frederick	2	F	rederick	
	Funeral Director		5. Social Security Number 147–16–6045	6. Sex 7. Ag	e (In yrs. last birthday) 79 Yrs.	If Under 1 Year	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea	9. Birth Cou	place (State or Foreign intry)
			Usual Residence of Decedent				1 110	.5	72-1 NGW	
	urylan show		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 11√2 Yes 2 □ No
	88-f.	octo	Maryland Frederi	Lck	Frederio		.,	10- 0	Citizen of What Cou	
	with th	흅	10e. Street and Number			10f. Zip Code				
	eath vs 23,	era	100 Burgess Hill	12. Was Decedent	Ever in U.S. 13.	21702 Was Decedent of Hist	panic Origin? (Specif		ted State	
10	r Iten	Funeral Director	1 ☐ Never Married 2⊠ Marr	Armed Forces? ied 1 ☐ Yes 2 ☐ 1	No	Was Decedent of Hisp If Yes, specify Cuban,		an, etc.)	Black, White	, etc.
93	ours a	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: Whi	te
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other then "natural" or items 23s or 28s-f show event, the Medical Exam for must be notified at	Completed	15. Decedent (Specify only highes		16a. Dece (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of working	16b.	Kind of Business/li	ndustry
121	Mithin hen	d E	Elementary/Secondary (0-12)	College (1-4or 5	5+)			Шоо	1+h Como	Dunfaccion
N	e filed v Il Hygie other t vent, th		17. Father's Name (First, Middle,	Last)	Nurse		8. Mother's Name (F			Profession
Maryland	lid be lental rked o	To Be	John	Valen	tini		Ester			Straffe
ary	d 2 should th and Mer ?7 Is marke treumetic	-	19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street an	d Number or Rural R	loute Number, City	or Town, State, Zi	p Code)
	and 2 salth a n 27 le		Richard Dolman	/ spouse						yland 21702
ore	of Healt of Healt if item 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	ı		Location - City or T	
Ë	nit. Pages vartment of I ortent: If ite injury or or		`4 □Donation 5 □ Other (S	pecify)	Pine Gro	ve Cemeter			Airy, M	
Baltimore,	permit. Page Department ( Importent: If any injury or once.		21. Signature of Fuperal Service	Licensee		2. Name and Address				
Е	46200		23a. Part1. Enter the disease, or	complications that causer					ick, Mar	yland 21702 Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each li	ine.	E	1 %			Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Thesu	a consequence of):	-diac A	why them			_C
	Examiner				. 4 0011004001100 01,1					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	cuted nd transii	Examiner	that initiated events	c						
ó,	te be executed ysicien and te burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
68760,	# ₹ #	dical		d						
9 ×	death certifical e attending phi d for use as th	Physiclan/Med	IF FEMALE:	23c. If yes, outcome					23d. Date of deli	verv
Вох		clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant a		□Ectopic pregnancy □ Other (specify)			Month	Day Year
0	at the de by the a stached	hysi	9 Unknown	9☐ Unknown						
s, P	The law requires that the site has been signed by the bage 2 should be detache.	by P	Part II. Other significent condition	ons contributing to death b	out not resulting in the u	underlying cause giver	n in Part I.	23e. Did tobacc		the cause of death?
rd	en sig		End Stage	Kenal 1	disease			1 ☐ Yes	2₽No 3□Pro	bably 4 Unknown
ဗ္ဗ	e law requ has been je 2 shoul	Completed	Hault onse	et Diabe	tes			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
<u>=</u>		Con	Peripheral	Varcula	- Dieg	e		performed	death?	2 🗆 No
Vita	iicien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:		Other	26. Place of Death (0			
of Vital Record	Phys this ral dii	. To	1 Yes 2 No 27. Manner of Death	1 🔲 Inpati		nt 3LI DOA	4 LI Nursing Home	5 Residence d. Describe how in	6 □Other (Speci jury occurred	ify)
	After fune	tion	1 Natural 5 Pendir 2 Accident investi		ay Year) Injury	Work?	es 2 No			
Division	or Attend after death Director: A in by the f	ifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of In	jury - At home, farm, si	treet, factory, office	28	f. Location (Street City or Town, St.	and Number or Ru	ral Route Number,
ā	s after s Dire	Certification:	4   Horricide	building, e	tc. (Specify)					
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical		ng Physicien: To the best Exeminer: On the basis of and manner st	of examination and/or is					
	To the within To the comple	Me	29b. Signature and title of certifie	ir 0		29c. License	number	29d. I	Date signed (Month	, Day, Year)
				In In	8		17679	S	11/2001	£
	4		30. Name and address of person	who completed cause of	death (Item 23a) (Type ) Y Solutex	0 1 .1	5, Fled	ende	HD:	2(20]
		ate	31. Date filed (Month, Day, Year,		trar's Signature	4 1				
	Regist	rar	MAT	1 4 2004	Je per	N Apo	als			

					Mental Hyg	•	16665		
10,	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Mario  C.  Del Sig	nore	2. Date of Deat Month May 1	Day Year	3. Time of Death 8:00 am		
A	Examir		4a. Facility Name (If not institution, give street and number) 311 Sunset Drive	4b. City, Town, or Location of De		4c. County of Dea	th		
c	Funeral Director		5. Social Security Number 705-14-0144 6. Sex 1 1 1 2 1 F 87 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi		9. Bir 1917	thplace (State or Foreign buntry) WV		
	Maryland a-f show	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Lot   LaV				10d. Inside City Limits 1 □ Yes 2 □ No		
	h with the 3s or 28s	Funeral Director	10e. Street and Number 311 Sunset Drive	10f. Zip Code 21502	10	Og. Citizen of What Co	ountry?		
980	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or tems 23a or 28a-f show event, the Medical Examiner man be motified at	by	1 Never Marriad 2 Marriad 1 Was 2 No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White			
Maryland 21215-0036	in 72 ho n "natur Aedical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	rorking	6b. Kind of Business/Industry			
212	filed within 72 Hygiene. sther then "ne ent, the Wedic	Com	Senio	r Train Master			Western Md Railroad		
land		To Be	17. Father's Name (First, Middle, Last) Sante Del Signore		ame (First, Middle, M (Centiofor	<sub>laiden Sumame)</sub> nti) Del Sigr	ore		
	d 2 stranger		19a. Informant's Name/Relationship (Type, Print) Clyde Putnam Jr. nephew 19b. Mailir 1 R	ng Address (Street and Number or F ed Fox Drive		City or Town, State, a			
Baltimore,	or oth		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  1  Donation 5 Other (Specify)	sition (Name of natory or other place) morial Park	Date 2 5/15/2004	Oc. Location - City or Town, State  Cumberland MD			
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	Name and Address of Facility al	Home, PA				
	Physician /Medical Examiner		23a. Party. Enter the disease, or complications that coused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	108 Virginia Aver er the mode of dying, such as cardi	ac or respiratory arre	and, MD 215	Approximate Interval Between Onset and Death		
	ysicia	dical Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):						
O. Box 6	ding se a	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year		
ecords, P.	signe d be d		Part II. Other significant conditions contributing to death but not resulting in the un NON SMALL CEIL Lung	nderlying cause given in Part I.		acco use contribute to			
H Reco	To the hosterial of whether the death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Completed by	PARKINSON'S Disease		24a. Was an autopsy perform	egy death?	topsy findings available ompletion of cause of		
Vita	ysician is certifi director	o Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	0.4	eath (Check only one	) ince 6 Other (Spec	de A		
io Liois	ath. or: After th	ation: T	27. Manner of Death  1 Natural 5 Pending investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)	28c. Injury at Work? M 1   Yes 2   No	28d. Describe how		ny)		
	rs after de al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	281. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
	in 24 hour	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)		
	with Com	2	29b. Signature and title of certifier  MD	29c. License number D54765		d. Date signed (Month	,		
,	7 KS		30. Name and address of person wire completed cause of death (Item 23a) (Type, F	Print)					
ľ	Stat	е	Robert E. Rapp, M.D.; 912 Seton Drive	e; Cumberland, ML	21502				

D1		1 - For Amend Item #17   State Registrar  1. Decedent's Name (First, Middle, Las	t)	Ce	ertificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death	
Physic /Medi		Malcolm E	. Durfee				May	3 Day 2004 ar	4:30A	
Exami		4a. Facility Name (If not institution, give	street and number)			or Location of Dea	ath	4c. County of Deat		
		Beverly Healt				stown		Washin	gton	
Funeral Director		058-18-9662	7. Age (In yrs.	last birthday Yrs.	Months Days	Hours Mir		y, Year) Co	hplace (State or Forei untry) W York	
show	= N	Usual Residence of Decedent  10a. State  10b. County Washingt	con Ha	ty, Town or L agers	ocation town				10d. Inside City Limit	
28e-f	ecto				T					
tems 23a or 28e-f show	Funeral Director	750 Dual High	way		10f. Zip Code 21740	)		10g. Citizen of What Co USA	untry?	
Items Items	ne	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of I	Hispanic Origin? (	Specify Yes or No-	- 14. Race - Ame Black, White		
5 2	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		nto ritoan, etc.)	s Mhite		
- 1	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retire	oation during most of w d)	orking	16b. Kind of Business/	Industry	
	E	12	College (1-40/5+)	Sheet	t Metal	Worker	s	Construc	tion	
Mental Hygi Merked other latic event, t	To Be C	17. Father's Name (First, Middle, Last)  Ennis B. Durf	Ennis B. Durfee				<sub>ame (First, Middle,</sub> eth Bai			
h and 7 Is m traum		19a. Informant's Name/Relationship (7) Sharon Rice Pooman						or, City or Town, State, 2		
9 5 5		20a. Method of Disposition			osition (Name of omatory or other pla	147	Date	20c. Location - City or		
3.2 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	<i>emetery, cre</i> i thsbu	matory or other pla rg Cremat	ory 5/5	5/2004	Smithsburg,		
		21. Sign sture o Funeral Survice Licens							_	
Depa Impo any ir		taul 1. to	chisampi MO	0849 4	8 S. Chur	ch St.,	Waynesbo	ro, PA 1726		
hysician /Medical		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	K	/		cor respiratory and		Approximate Interval Between Onset and Death	
xaminer	_	Sequentially list conditions,	. In	1 8	tage	Klen	culia			
nsit	in in	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	luence or):	•					
hysician and the burial-transit	ical Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
g phy as the		-	J							
within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Il death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Date of deline Month	very Day Year	
n signed by the a ld be detached f		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	underlying cause giv	en in Part I.		bacco use contribute to	the cause of death?	
has been si ge 2 should b	Completed		Viceer	ili'l	hus 20	eers-	24a. Was a	sy prior to c	opsy findings availal ompletion of cause of	
icate r, pag							perform 1 Yes	2□No 1□Yes	2 2 No	
certif	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth		ath (Check only on			
r this rral di	. To	1 Yes 20 No	1   Inpatient 2	28b. Time o	nt 3 DOA	4 Nursing I		ence 6 Other (Spec	fy)	
Th. Afte	tion	1 Vatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2⊟No	200. 0030100 110	ow injury occurred		
after death Director: A in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str		2.20	28f. Location (Si City or Town	treet and Number or Rui n, State)	et and Number or Rural Route Number, State)	
within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ledical C	29a. Certifier 1 Dertifying Physical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)	
	Med	29b. Signature and title of certifier	and mainter stated.		29c. Licens	e number	2	29d. Date, signed (Month,	Day, Year)	
o the		$\sim 1$	0.0		0.7	>60		5/2/50	,. <del></del> ,	
To the	-	30. Name and address of person who co	Impleted cause of death (Item		Da	87		5/3/6x gerston		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 16 45 Blanche Lorraine Davis 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** AlleGANY SACRED HEART HUSPITAL CUMBERLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1937 Hours 1 M 2 XF Mar 26. 233-58-3323 Yrs 67 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show other traumatic event, If a Medical Exact printed by notified at WV Mineral Fort Ashby 1 ☐ Yes 2√☐ No Director 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ō HC 86 Box 23 26719 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Horne 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lloyd Welker, Sr. Hazel (Ash) Welker Taylor 19a Informant's Name Name Richard Davis 19b. Mailing Address (Street and Number or Rural Route Numbér: City or Town, State, Zip Code) HC 86 Box 23 Fort Ashby WV 26719 Informant's Name/Relationship (Type, Print) son 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Fort Ashby Cemetery 5/13/2004 Fort Ashby WV \* 4 ☐ Donation 5 ☐ Other (Specify) any injury 21. Signature of Funeral Service Licenses 22. Nam Scaffein Fundial Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part/ Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final HEART CONGESTIVE FAILURE Physician disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): Examiner ARCINOMA of OVARIES WITH CARCINOMATOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit GNA LIVER METASTASIS 3 YEARS UNG that initiated events resulting in death) Last and Due to (or as a consequence of): certificate be exec the attending physician Division of Vital Records, P.O. Box 6876 Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 17 4 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ö in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 □ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Anatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 208377 -10.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Velandia, 902 SETON DRIVE, SUITE #303, CUMBERLAND WD 31209 Uriel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 2 5 2004

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yeer Zetta Evans May 16, 2004 10:35 pm™ /Medical 4e. Fecility Name (If not institution, give street and number)
13003 Mallard Street 4b. City, Town, or Location of Death 4c. County of Death Examiner Cresaptown Allegany 5. Social Security Number 217-10-7356 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Jul 19, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 ■ X 87 Director Usual Residence of Decedent Allegany 10c. City, Town or Location Cresaptown 10d. Inside City Limits MD Iteme 23a or 28a-f ehov Be Completed by Funeral Director 1 Xes 2 No death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12724 Darrows Lane 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Medical Examiner filed within 72 hours after 1 Yes 2 Xo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: 3 ₩Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last)
John Robinette 18. Mother's Name (First, Middle, Maiden Surname) .. Pages 1 and 2 should be fill timent of Health and Mental Hy tant: If item 27 te marked oth Margaret Benn Robinette 2 19b Majling Addless (Street and Number of Rural Route Number, City or Town, State, Zip Code) 13003 Mallard Street Cresaptown MD 21502 19a. Halomant's Name/Relationship (Type, Print) son 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Sunset Memorial Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. 5/20/2004 Cumberland MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nam Octarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) 2 1/2 years /Medical Due to (or as a consequence of): **Examiner** Renal Cell CA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of mury that inflated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this conditions. use as the burial-transit COPD Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Day Year P.O. 1 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Anemia 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖫 Other (Specify) son s home 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation iours after death neral Director: / filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D59121 M.D. May 17, 2004 person who completed cause of death (Item 23a) (Type, Print) Tasneem Malik, M.D.; 625 Kent Avenue; Cumberland, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2004

MAY 25

	erien.		1 - State of Maryland		artment of tificate of		ind Me		iene	2004	16669
	Physici		1. Decedent's Name (First, Middle, Last)  Dustin Thomas Eichelberger					2. Date of Dea Month	h Day	7 004	3. Time of Death
100	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town	, or Location of	f Death	· tacy	4c. Co	ounty of Deetl	
		Hay.	Shady Grove Adventist Hospital			ersburg			Me	ontgom	
- 67 - 12 - 12	Funeral Director		5. Social Security Number 216-41-3994 6. Sex 1XI M 2 F 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Yea Months Day			8. Date of Birth (Month, Day) Mar 24	Ĭ994	9. Birth Con Free	nplace (State or Foreign untry) derick, MD
	yland sow		Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Lo	cation						10d. Inside City Limits
	e Mar	ctor	MD Frederick	Brunsw	ick						1 ∑ Yes 2 □ No
	h with th	al Director	10e. Street and Number 302 Ninth Avenue		10f. Zip Code	21716		1	0g. Citize	usA	untry?
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28a-f show event, tris Mudical Exartirar must be notified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.:  Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	į .	Vas Decedent of Yes, specify Cu		in? (Spec Puerto R	rfy Yes or No- ican, etc.)		Race - Amer Black, White Decify: W	
9200-51212	d within 72 h giene. er then "natu rine Mudical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give :	OO NOT use retii	rk done during most of working					Elementary
Maryland	la pe	To Be C	17. Father's Name (First, Middle, Last) Gerald Lloyd Eichelberger, Jr.					(First, Middle, I Ann Gu		тате)	
	d 2 sh th and th and ?7 Is m traum		19a Informant's Name/Relationship (Type, Print) Patricia Ann Fogle, Mother		g Address <i>(Str</i> e Ninth A						ip Code)
Baltimore,	Pages 1 an nent of Heal out: If item 2 ury or other		Terbunal 2 Defination 3 Definition State		sition (Name of natory or other po le Heigl	1	Da 78/2	0.1		ion - City or T	
Palti	permit. Page Department of Importent: If any injury or once.		21. Signature of Fureral Service Licensee  Barbara A. Williams, Owner	J	Name and Add ohn T. V	ress of Facility	ıs Fu	neral H	ome		
8/60,	Certificate be executed diplomatic and horizontal and care as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequ	ococc rence of):		nen ir		,	ISI,		Approximate Interval Between Onset and Death
O. BOX 6	death e atter	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	23d. Da Mo				ne of delivery nth Day Year			
cords, P	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resu	Iting in the un	derlying cause g	liven in Part I.		23e. Did tob			the cause of death?
ב ב	icien: The law rec certificate has bee rector, page 2 shor	Completed						24a. Was ar autops perform 1 Yes 2	/	4b. Were autoprior to codeath?	opsy findings available ompletion of cause of
N (G	ysicien: is certific director,	Be	25. Was case referred to medical examiner?				of Death (	Check only one			<i>T</i>
5	ding Phys n. After this funeral di	tion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju		28	a 5 ☐ Reside d. Describe ho			fy)
DIVISION	or Attending after death. Director: After In by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre				f. Location (Str City or Town		umber or Run	al Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  (Check only one)  1 Certifying Physician: To the best of my know and manner stated.	vledge, death on and/or inv	occurred at the estigation, in my	time, date and opinion, death	place, an	d due to the ca l at the time, da	use(s) and te and pla	d manner as s ce, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier Law for Bell, M	ND.	29c. Licer	565	52	- 29	d. Date si	gned (Month,	2004
	2	11	30. Name Ind address of person who cook legical displayed of death (Item Keisha Crawford - Belly MD 90	23a) (Type, F	edical C	enter D	rive	Roc	kvill-	e, Ma	2004 ryland
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signate  ANY 1 0 2006	ure	9 10	arth					J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 30, **Physician** 2004 8:50A. Linda Marie Fine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) Jan. 11, 1943 If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 KF Pennsylvania Director 161-34-8380 the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f ehow any intry or other traumatic event, the Medical Examiner must be natified at once. 1 ☐ Yes 2 ☐ No Maryland Prince George's Beltsville Completed by Funeral Director 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 20705 4633 Quimby Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 21215-0036 1 ☐ Yes 21 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home Maryland 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sifton S. Jaynes Lavina Cramer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4633 Quimby Avenue Beltsville, Maryland 20705 Timothy Fine -Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Metropolitan Crematory 5/5/2004 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705
Approximate
Interval Between
Onset and Death \* 4 ☐ Donation \* 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Danald rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Recurrent Abdominal Wall Abscesses **Physician** disease or condition resulting in death) years /Medical Due to (or as a consequence of): **Examiner** Multiple Colonic Perforations years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Chronic high-dose Steroids resulting in death) Last Due to (or as a consequence of): Rheumatoid Arthritis attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Day Month 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Methicillin resistant staphylococcus aureus infection; 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an osteoporosis; Chronic obstructive pulmonary disease page 2 2 XNo 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes = 2**X** No 2 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; the Hospitel or Attending Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D33159 May 2, 2004 Collen 16

State Registrar 31. Date filed (Month, Day, Year) MAY 0 4 2004 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth Kevess-Cohen, M.D. 8700 Georgia Avenue, #400 Silver Spring, Maryland 20910

			Amend Item 1 per Dr., State of Maryland / Department of Certificate	of Health and Mental Hygiene 2004 1667
	Physic	ian	1. Decedent's Name (First, Middle, Last) Glen Frazee	2. Date of Death Month / Day / Year 3. Time of Death
	/Medi		Frazec, Glen	4/28/04/0300
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			5 Social Security Number 6 Sex 7 Ane (In was last hirthday) If Under 1 Y	Grantsille, Garett
	Funeral Director	Г		ear If Under 24 Hrs. ays Hours Min. S. Date of Birth (Month, Day, Year)  MARCH 18 1909 MARYLAND
	and *	]	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	the Marylar 28e-f show cottlied at	5		1 Xyes 2 No
	the N	Director	MARYLAND GARRETT FRIENDSVILLE  10e. Street and Number 10f. Zip Co	de 10g. Citizen of What Country?
	with po a	ā		1531 U.S.
	leath	era		
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, then "netural", or items 23e or 28e-f show tiem 27 is marked other than "netural", or items 23e or 28e-f show other traumatic event, the Marical Examinat must be rotifiled at	by Funeral	Armed Forces? If Yes, specify  1 □ Never Married 2X Married  1 □ Yes 2 X No  If Yes, Specify  1 □ Yes 2 X No  If Yes, Give  1 □ Yes 2 X	Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.
21215-0020	in 72 hou n "netura	Completed	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work diffe. DO NOT use n	ccupation 16b. Kind of Business/Industry one during most of working etired)
212	d within giene. r than "	Eo	Elementary/Secondary (0-12) College (1-4or 5+)  12 BUS DRIV	ER SCHOOL DISTRICT
pu	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Maryland	ould b Ment arked	2	ISAAC FRAZEE	KATE FEARER
Jar	2 sho and is me	1 3		treet and Number or Rural Route Number, City or Town, State, Zip Code)
	es 1 and 2 of Health item 27 i			RIDGE ROAD, FRIENDSVILLE, MD 21531
Baltimore,	Pages 1 nent of H nrt: if ite		20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of Community) and Community of Other Community (Name of Community) and Community (Name of Community)	of Date 20c. Location - City or Town, State
Ħ	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Specify) ASHER GLADE CEM	
Bal	permit. Pages Department of important: if it eny injury or once.			ddress of Facility 60 W. MAIN STREET
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of	UNERAL HOME, P.A. FROSTBURG, MD 21532  I dying, such as cardiac or respiratory arrest, Approximate
	Physician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Interval Between Onset and Death  2 week
Box 68760,	death certificate be executed a attending physician and d for use as the burial-transit	Physiclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.   Mulfinfarch dem  Due to (or as a consequence of):  Due to (or as a consequence of):	enti man gar
E	e dea he att	sicl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.  23b. Did tobacco use contribute to the cause of death
P.O.	res that the designed by the a	by Phy	Peripheral Valuela discuse	1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknow
Records,	requi	Completed b	Meripheral Vascula diseuse Myterta sina, chronic rend t.	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
Ě	The law ate has page 2	ĕ		1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
'ita	ysician: The l s certificate ha director, page	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)
of Vital	hysic nis ce il dire	၉	1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ursing Home 5 Residence 6 Other (Specify)
Division o	ending Pleath.	Certification:	2 ☐ Accident investigation M	Injury at 28d. Describe how injury occurred Work? 1 ☐ Yes 2 ☐ No
Divi	tai or Att rs after d ai Direct ed in by	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	fice 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the basis of examination and/or investigation, in rand manner stated.	my opinion, death occurred at the time, date and place, and due to the cause(s)
	Vith Tot	Σ		cense number 29d. Date signed (Month, Day, Year)
			// Must for	31408 4/2/04
_				arrett Highway, Oakland, MD 21550
	Sta Registr		31. Date filed (Month Day, Year) MAY 2 I 2004  Service Signature  Apouls	

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	Physic	ian	Decedent's Name	,	-,,								2. Date of I Month		ay `	rear .	3. Time	of Death
	/Med		Je 4a. Facility Name (II		Garlan			Sr.	45 O': T				May		2004		12:	45 P
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	Funeral		5. Social Security N		6. Sex		Pice Age (In yrs. la	ast birthday)	TOWS		If Under	24 Hrs.	8. Date of I		Balti			or Foreign
	Director		220-32-3		11 M ≥		68	Yrs.	Months Da		Hours	Min.	arch	Day, Yea	(r)	Cour	ntry)	3
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	show	_	10a. State	10b. Count	У		10c. City	, Town or Lo	cation							1		ID City Limits
	Ba-f s	cto	MD	Car	roll		We	stmir	ster								1	s 2 □XNo
	or 20	Dire	10e. Street and Nun						10f. Zip Cod					10g. C	Citizen of Wh	at Cour	ntry?	
	ath w	a	254 N.	Gors					21	157	7			1	U.S.A			
	er de Items	nue	11. Marital Status		An	ned Forces			Was Decedent of Yes, specify C	of Hisp Juban,	oanic Ori Mexican	gin? (Spe n, Puerto	ecify Yes or I Rican, etc.)	No-	14. Race - Black,	Americ White,		
36	rs aft	γF	1 Never Marrie 3 Widowed	ed 2√ Ma A Divorce		]Yes 2.∏ ∕es, Give 4 ar or Dates	Λ		1 □ Yes 2 💢 1	No	Specify:				Specity:	Whi	te	
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Maryland	2 should be filed with and Mental Hygiene. Is marked other that aumatic evant, the N		19a. Informant's Na	me/Relation	ship (Type, Pri	int)		19b. Mailir	g Address (Stre	et and	d Numbe	er or Rura	l Route Num	ber, City	or Town, St	ate, Zip	Code)	
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ore	of H of H if iter	1	20a. Method of Disp 1 Burial 2 5		3 DRemova	I from Stat		ace of Dispo	sition (Name of natory or other)			D	ate	20c. l	Location - Ci	ty or To	wn, State	
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Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 any injury or other <u>once</u> .		21. Signature of Fur	neral Service	Licensee		5	22	. Name and Ad	dress (	of Facility	У			- 33			
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			23a. Part . Enter th shoo, or hear	e disease, d t failure. Lis	or complications t only one caus	s that cause se on each	ed the death. line.	Do not ent	er the mode of o	tying, s	such as	cardiac o	respiratory	arrest,	, PI		2115 Auproxima Interval Be	etween
	Physician		disease or condition	rinar	- a.	C	olo		Bucei								Onset and	Death
	/Medical Examiner		resulting in death)			Due to (or a	s a conseque	ence of):									8	
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	ted	Examiner	Sequentially list con it any, leading to init cause. Enter Under Cause (Disease or it	nediate tying . niurv	<	to (or a	a a conseque	тсе от.										
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Box	leath certiff attending I for use as	Z	IF FEMALE: 23b. Was decedent	pregnant			e of pregnan								23d. Date of	of delive	n	
m	death e atte d for	cia	in the past 12 r	nonths?	4	Pregnant a	2 ☐ Fetal c at time of dea		Ectopic pregnal Other (specify)						Month		,	Year
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	The law requires that the death certifule has been signed by the attending tage 2 should be detached for use a	by P	Part II. Other signific	cant conditi										tobacco	use contribu	ite to th	e cause of	death?
ıd	w require been sig should t		scle	VOSI	ng	chol	mgi	tis	with	w	er f	Ailv.	1	Yes 2	15 out	] Proba	ably 4 🗆	Unknown
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	hysic his ce I dire	၉	1 Tes 2	10	Hospital	: 1 🗌 Inpat	ient 2 🗆 El	R/Outpatient	3 □ DOA 0	Other:	4 🗆 Nur	sing Hom	ne 5 Res	idence	6 Other	Specify	Hoy	*16
	fter ne	ë.	27. Manner of Death  Natural	5 🗆 Pendi		Date of Inj (Month, D	ury 2 a <i>y Year)</i>	8b. Time of Injury	28c. In	jury at		2	8d. Describe	how inju	ary occurred		υ	
sio	Mtsndii death. ctor: A y the fu	cati	2 Accident 3 Suicide		igation						s 2 □ N	10						
Division		Certification:	4 Homicide	deterr		Place of Ir building, e	njury - At hom etc. <i>(Specity)</i>	e, farm, stre	et, factory, offic	е		2	8f. Location City or To	(Street a	nd Number ( e)	or Rural	Route Nun	nber,
	pital ours a eral D		00- 0-45	M 0-46.	25													
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in E	edical	29a. Certifier (Check only 4 one)	Medicel	exeminer: Or	the basis of manner s	ot examinatio	edge, death n and/or inv	occurred at the estigation, in my	time, opinio	date and on, death	i place, a h occurre	nd due to the d at the time	cause(s , date an	<ul> <li>and manned</li> <li>place, and</li> </ul>	er as sta due to	ited. the cause(:	s)
	o the o the	Mec	29b. Signature and to	itle of certifie		2 mailler 5	ialec.		29c. Lice	nse nu	umber			29d Da	ite signed (A	Aonth C	av Year	
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•	and a		30. Name and address	//W/	who complete	d cause of	death (Itam C	3a) /Tu=o 1	Print)									
	り		III D C	ss of person	GB M		701	N. C	harlos.	5+	. /	Bal	6. ma	1 2	1205	-		
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ORIGINAL

May 10, 2004 1245m

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				State of Ivia	_	•	ificate of		i wentai m		2001	. 16	672	
	Physicia	an	Decedent's Name (First, Middle, Last     T ELLT C	EDWARD HA	UM				2. Dete of D	eath Day		3. Time of		
To and the second	/Medic	al	4a Fecility Neme (If not institution, give		TUIN			4b. City. Town. o	May or Location of Dea		2004 County of Deet	7:15	AM	
1	Examin	er	107 Eyler Road	,				Thurm			Freder:			
100	Funeral Director		210-34-3423	X 7. Age	(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days		rs. 8. Date of B			hplace (State o untry) Cyland	or Foreign	
	/land		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Loca	tion					10d. Inside Ci	ty Limits	
	a Mar	cţo	Maryland Frederic	ck	Thurmo	nt						1 ☐ Yes	2 <b>X</b> No	
	vith th	Olre	10e. Street end Number				10f. Zip Code				en of What Co	untry?		
	laath me 23	eral	107 Eyler Road	12. Was Decedent E	ver in U.S.	13. Wa	21788		Specify Yes or N		S.A. 4. Race - Ame	rican Indian		
21215-0020	parmit. Pagas 1 and 2 should be filled within 72 hours aftar death with the Maryland Department of Health and Mantel Hygiane. Department of Health and Mantel Hygiane. Inferiorate if them 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Amed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:			es, specify Cuba ∃Yes 2Ñ_No		(Specify Yes or Narto Rican, etc.)		Black, White			
15-0	"natu	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Deceder (Give kii	nt's Usual Occup nd of work done of NOT use retired	ation during most of w	orking	16b. Kind	d of Business/	Industry		
212	withir than	ф	Elementary/Secondary (0-12)	College (1-4or 5+	)		ntenanc			Conc	mpany			
pu	e filad al Hyg other vent,	Š Š	17. Father's Neme (First, Middle, Last)						ame (First, Middle	Concrete Company ne (First, Middle, Maiden Surname)				
yla	ould b Manta arked arlc e	To Be	Clarence Edward Ha		- 9			Carrie	Elizabe	th And	drew			
, Maryland	and 2 sh aalth and n 27 ie m ner treum		19a. Informant's Name/Relationship (T) Virginia G. Hahn	pe,Print) (Wife)	10	7 Ey	ler Roa	d, Thurr	Rural Route Numb				))	
Baltimore,	agas 1 nt of H : If ita	ı	20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ F	lemoval from State			ion (Name of tory or other place		Date		ation - City or			
itin i	nit. Pa artma ortant injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Furneral Service Lights	BB 1	blue, k	_	Cemete:	ry ss of Facility	5/13/04	Thurr	nont, M	laryland	1	
ĕ	ing Dap		* HutE.	Luc		ROE 615	ERT E. I	DAILEY &	SON FUI	NT. MI	HOMES,			
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ac or respiratory a	irrest,	1	Approximate Interval Betw Onset and D	veen						
1	/Medical		Immediate Ceuse (Final disease or condition	07	= 1 =			/_	. //					
3	Examiner	_	resulting in death)	D	ue to (or as a c	onseque	nce of):							
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oʻ	e axec lan an urial-tra	EXa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						11 crl				(200)	
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Вох 6	nding usa as										1			
Ä	raquiras mat ma daam car bean signed by tha attandir should be datachad for usa	Physician/M	Part II. Other significant conditions con	tributing to death but	not resulting in	the unde	riving cause give	en in Part I	23h Did	tohacco us	se contribute	to the cause of	(death?	
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ds,	signer d bed	S S	( ) ( ) ( )	m 765	) /7	0 1		C 01717			045.16			
Records,	v raqu bean shoul	ete							24a. Was perfo	an autopsy med?	a	Vere eutopsy tir vailable prior to ompletion of ca		
Be E	na la la sata has	Completed							10	Yes 2		idéeth? □Yes 2□N	No.	
of Vital	cartificata		25. Was case referred to medical examiner?					26. Place of De	eath (Check only o	/ \				
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uo g	th. Aftar funar		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day )	(ear) 28b. Ti	me of jury	28c. Injury Work M 1 □ \	at ? /es 2 □ No	28d. escribe	how injury o	occurred			
Division in a standing	aftar daal Director: d In by tha	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc.	r - At home, fam (Specify)	m, street			28f. Location (: City or To	Street and I vn, State)	Number or Rur	al Route Numb	er,	
e Hospita	within 24 hours after death.  To the Funeral Director: After this cartification occupiataly filled in by the funeral director.		29a. Certifier 1 Critifying Phys (Check only one) 2 Medical Examin	ician: To the best of ref. On the basis of each and manner state	camination and/	death od or inves	curred at the tim ligation, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) ar date and pl	nd manner as s ace, and due t	stated. to the cause(s)		
To the	within conf		29b. Signature and title of certifier				29c. License				signed (Month,			
				21	- 5		101	46 26		m.	2 (1	200	25	
	601	3	30. Name end address of person who con	mpleted cause of dea		ype, Prir	nt)	7 41	=			0 -		
	State	3	31. Dete filed (Month, Day, Year)	32. Registrer's	Signature	/			F	C1 7-	al II	1 2	701	
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DHMH	H 16 Rev 6/95						/ /							

State of Maryland / Department of Health and Mental Hygiene 2001 16674 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 **Physician** Beverly Jean Huey :15 PM 04 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITAL ALLEGANX HEART CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months 70 Director 279-30-2757 09/16/1933 Ohio Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, if a Madical Exeminar must be notified at 10d. Inside City Limits MD Allegany Director 1 ☐ Yes 2 ☐ No LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Mary Court 21502 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or item eny injury or other treumatic event ∑Yes 2 No 1951 -1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 1952 White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Emerson Marker Mabe1 Kellev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Mary Court, LaVale, Maryland Ralph R. Huey / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State MD Vet. Cem. @ Rocky Gap 05/17/2004 Flintstone, MD ¹ 4 ☐ Donation 5 Other (Specify) 21. Signature of Fureral Service-Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset, and Death Immediate Cause (Final Ph sician m05 disease or condition resulting in death) /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnap 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 EP/Outpatient 3 DOA After th 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funerel Director:
completely filled in by the 6 Could not be 3 M Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certified IIVA 30. Name and address of person who complaind cause of death (Item 23a) (Type, Print) 925 BISHOPWaish Road Cumberland Wagoner 32. Registrar's Signature State Registrar

haiai.		State Registrar	- (	C	ertificate of Death	2. Date of Dea	Reg. No. 200	3. Time of Death
hysicia		1. Decedent's Name (First, Middle		<b>a</b>		May 8	. 2004	
/Medic	al	4a. Fecility Name (If not institution	Robert Hardee		4b. City, Town, or Location of		4c. County of D	
xamin	er	Memorial I			Easton		Talbo	t
ral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthd	Months Days Hours	Min. (Month, Day		Birthplace (State or Foreign Country)
r		214-34-7716 Usual Residence of Decedent		67 Yrs		August 24	1, 1936 I	Maryland
		10a. State 10b. County		10c. City, Town o	Location			10d. Inside City Limits
	ctor	Maryland Caro	oline	Dentor				1⊈Yes 2 □No
	Funeral Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What	Country?
Back	E a	613 Market Stre	et 12. Was Decedent	Ever in U.S.	21629  3. Was Decedent of Hispanic Original	in? (Specify Yes or No-	United Sta	merican Indian,
FLID	;	1 Never Married 2 Mar	ined Armed Forces?		Was Decedent of Hispanic Orig tf Yes, specify Cuban, Mexican,	Puerto Rican, etc.)		/hite, etc.
-	6	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No Specify:			casian
etec		15. Deceden (Specify only highe	nt's Education st grade completed)	16a. D	acedent's Usual Occupation ive kind of work done during most e. DO NOT use retired)	of working	16b. Kind of Busine	ess/Industry le Service
	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			Stat	
	ပို	17. Father's Name (First, Middle,	Last)		ookkeeper	's Name (First, Middle,		
	To Be	Paul Ca	sper Hardee			en Marie Ho		
		19a. Informant's Name/Relations		19b. M	ailing Address (Street and Number	or Rural Route Number	ar, City or Town, Stat	e, Zip Code)
1		Joan Ann Hard	ee Wife	613	Market Street,	Denton, Ma	ryland 210	629
l		20a. Method of Disposition 1   Burial 2   Cremation		9	sposition (Name of crematory or other place)			
1		*4 □ Donation 5 □ Other (5		Denton	Cemetery 5 22. Name and Address of Facility	5/12/2004	Denton, I	Maryland
Ì		Ko. Pohl	D Max		Moore Funeral Ho 12 South Second	ome. P.A.	Mary	vland 21629
ı		23a. Part1. Ever the di -ase, o	r complications that cause	ed the death. Do not	enter the mode of dying, such as o	cardiac or respiratory ai	rest,	Approximate Interval Between
		tmmediate Cause (Final disease or condition	RP.	nal fo	aluel			Onset and Death
		resulting in death)	a. Due to ( r a	s a consequence of)				
					1 1 0			
		Sequentially list conditions,	b. #	eart	failure	•		
l	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	e a consequence of)	failure	•		
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	eco+ s a consequence of)		•		
	cal Examiner	that initiated events	C			•		
	ca	resulting in death) Last	C			•		
	Ea .	resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	c	s a consequence of)  e of pregnancy 2 □ Fetal death	3 □Ectopic pregnancy	•	23d. Date of Month	delivery Day Year
	ca	resulting in death) Last	c	s a consequence of)		•		•
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	s a consequence of)  e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)	239. Did t	Month	•
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	s a consequence of)  e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)		Month	Day Year te to the cause of death?
l	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	s a consequence of)  e of pregnancy 2 Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	1 🗆 '	Month obacco use contribut Yes 2 \( \sum \text{No} \) 3 \( \text{an} \)	Day Year te to the cause of death? Probably 4 Unknown
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c	s a consequence of)  e of pregnancy 2 Fetal death at time of death	3 Ectopic pregnancy 5 Other (specify)	24a. Was autopendo	Month obacco use contribut Yes 2 No 3 an 24b. Wernstern	Day Year  te to the cause of death?  Probably Unknown  e autopsy findings available to completion of cause of
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	edical Certification: To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	c. Due to (or a:  d. 23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown  ions contributing to death  al Hospital: Inpat  28a. Date of In (Month, D)  the basis and manner s  ing Physician: To the basis and manner s  ier	e of pregnancy 2 Fetal death at time of death but not resulting in t  tient 2 ER/Outp jury ay Year) 28b. Tir Inji njury - At home, farm etc. (Specify)	3   Ectopic pregnancy 5   Other (specify)    ne underlying cause given in Part I.  26. Place Other: 4   Nu ne of	24a. Was autoperformed by the state of Death Check on the control of Death Check on the control of Death Check on the state of Death Check on the control of	Month  obacco use contribut  Yes 2 No 3  an 24b. Wern  prior  deat 22 No 1   one  dence 6 Other (Show injury occurred  Street and Number own, State)  cause(s) and manne date and place, and  29d. Date signed (Month)	Day Year  te to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of h? Yes 2 No  Specify) or Rural Route Number, or as stated, due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** April 19, 2004 5:45 P. Bernard William Janifer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4707 68th Avenue Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1√2 M 2 □ F Washington, D.C. 62 577-54-6196 Director January 2, 1942 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 No Director Hyattsville Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4707 68th Avenue 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 specify: Black 1 Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Mechanic Dept. Of Housing permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Important: If item 27 is marked other than pripary or other fraumatic event. The 2006. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John H. Janifer Dorothy Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy W. Janifer (Mother) 4707 68th Avenue Hyattsville, Maryland 20784 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 27,2004 Suitland, Maryland Washington National \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sprvice Licensee Cel Part e and Address of Facility ROLLINS FLNERAL HOME, INC. 4339 HNT PLACE, N.E. WASHINGTON, D.C. 20019 or I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imp diate Cause (Final disease or condition resulting in death) Physician Lactic Adidosis 2nd to medications /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performed? Yes 2 2/10/0 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2XXNo this o 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after deat 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)
MAY 0 5 2004



29b. Signature

DC16879

addition of chath (Harm 23a) (1.1. W. Suite 1A50B Washington, D.C. 20010

April 26, 2004

4		1 - For State Registrar	State of Mary	land / D	epartment o Certificate d	f Health and of Death		giene Z Reg. No.	004	16677
Physic		Decedent's Name (First, Middle, Last     LEO LEONARD	•	SR.			2. Date of Dea Month MAY	Day	2004	3. Time of Death 4:40 a
/Medi Exami		4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of De			unty of Death	11.104
		Corscia Hills	Center			reville			en Ar	
Funeral Director		160-16-0617	97M 2□E	yrs. last birt	hday) If Under 1 Yours. Da		n. (Month, De)	h v, Year) 1924	9. Birthp Cour 1 Mary	place (State or Foreign ntry) yland
and		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location				1	I Od. Inside City Limits
Manyli f eho	ō	MD Kent		Rock	Hall					1X Yes 2 □ No
the f	Director	10e. Street and Number			10f. Zip Coo	de		10g. Citizen	of What Cour	ntry?
3 with	Ö	21356 Catholic	Ave.		216	61		U.S.	Α.	
be filed within 72 hours after death with the Maryland tall Hygiene. Idea Hygiene. Indother than "netural", or Items 23a or 28a-1 ehow event, the Mediral Examinar must be indiffied at	by Funeral	11. Marital Status  1 □ Never Married 2X Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	1944	13. Was Decedent If Yes, specify (	of Hispanic Origin? Cuban, Mexican, Puo No Specify:	(Specify Yes or No- erto Rican, etc.)	14. F	Race - Amend Black, White,	
2 hou		15. Decedent's Ed	fucation	16a.	Decedent's Usual Oc	cupation		16b. Kind o	f Business/In	dustry
hin 7.	Completed	(Specify only highest gra	College (1-4or 5+)		(Give kind of work do life. DO NOT use re	one during most of w stired)	rorking			
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should bind Ment	P.	Gerard Knoedle					ice 0'C			
2 shot and lam		19a. Informant's Name/Relationship (			Mailing Address (Str					
Tey Mary years and 2 should if Health and Mer teem 27 is marked other treumatic	1	Agnes Knoedler			0.0.Box 5		k Hall,		21661 on - City or To	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	High	v,ccematory or other View cial Gar	dens 5/	18/04	Fal1	Lston	, MD.
Departing Department of the police of the po		21. Siscature of Fundal Service Line	A .	0510	Galena 118 Wes	Funeral	Home of	Ster	ohen I	Schaec
		23a Part 1 Fater the disease or com		0510					MD. 2	21635 Approximate
	Q	23a Part 1. Enter the disease, or com shock or heart failure. List only Immediate Cause Final	one cause on each line.	302WI. 5011	or order the mode of	dying, soon as card	as or respiratory an		1	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death	a.	1 Fai						
Examiner		/	Due to (or as a co	nsequence o	r):					
st —	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co	nsequence o	f):					
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sicie Psicie	edical		d							
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The Could us, I. C. DOX 001 001, The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregn: 5 ☐ Other (specify				Date of delive Month	ery Day Year
that the detail	0	Part II. Other significant conditions of	ontributing to death but no	nt resulting in	the underlying cause	given in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?
uires sign	d by	Pneumonia, CO	PD				1 🗆 Y	es 2 No	3 Prob	ably 4 ⊟Unknown
w requir been si should	Completed	Chronic Back	Pain				24a. Was a	an 24		psy findings available
he lav	m.						autop	med?	death?	mpletion of cause of
	Ö	25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only or		1 🗆 Yes	ZLXINO
/sicie	0 0	examiner? 1 Yes 210 No	Hospital: 1 Inpatient	2 ☐ ER/Out	patient 3 DOA	Chan	Home 5 ☐ Resid		Other (Specifi	v)
g Phys er this eral dir	L iii	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. T		njury at Work?	28d. Describe h			
Attending Physicien: r death. sctor: Atter this certifics by the funeral director.	atio	1XNatural 5 ☐ Pending 2 ☐ Accident investigation		a// II		1 ☐ Yes 2 ☐ No				
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s afte	Cert	TIOMIDIO	building, old. (c	poony				, , , ,		
To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the th	edical		ysician: To the best of miner: On the basis of exa and manner stated.							
To ti withii To ti	M	29b. Signature and title of certifier	Salm.	nap		36054	2	29d. Date sig	ned (Month,	Day, Year)
1		30. Name and address of person who	completed cause of death	(Item 23a) (	Type, Print)				,	
71		Patrick J. S	hanahan M	D 1	20 Spee	r Rd. Ch	esterto	wn. M	ID. 21	620
	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	done	3		,		
Regist		MAY 2 5 200	14 Senew	1	span	2				

DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey **Physician** Louise R. Kirk 15, May 2004 4:30 pm/Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Williamsport Nursing Home
5. Social Security Number 6. Sex 7... Washington

9. Birthplace (Stete or Foreign Country) Williamsport ar If Under 24 Hrs. 8. D If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min. 84 Yrs. Director 13.1920 District of Columbia 579-12-0483 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f eho other traumsitc event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Directo Washington Hancock 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14504 Reel Road 21750 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>X</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 □ Widowed 4 □ Divorced Specify: White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Randolph Tucker Heflin Allie Compton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 14504 Reel Road Hancock, MD 21750 Beverly L. Zimmerman/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Peter's Catholic 05/18/04 Hancock MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Sdays a Cerebrovascular Examiner Due to (or as a consequence of) Physician/Medical Examiner hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): Division of Vital Records, P.O. Box 687 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Tes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | EP/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending after deeth.

I Director: Aft
of in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C completely filled edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Contra Kuttrer Band me May 16, 2004 D47451 CYNTHIA KUTTER Sands MD Williams port Nursing Home 154 North Artizan Street 31. Dete filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 16 Rev 6/95

B

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day **Physician** Robert May 4, 2004 Kerns 5:35 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles LaPlata Charles County Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer)
April 28,1921 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign **X**XM 2□ F Days Months Yrs 83 Director 212-20-8950 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b Count 10d. Inside City Limits 1 XYes 2 □ No Funeral Director Maryland | Charles Hughesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20637 15995 Fair Forest Place 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∑ Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify: White Completed by 3X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Local Union 1110 Carpenter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kerns Unknown John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15995 Fair Forest Place Hughesville, Maryland 20637 Michael Stewart/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Alexandria, Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 6,2004 Metropolitan Crematory Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility XIII Adams Funeral Home P.A. Aquasco, Maryland MO1323 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical ·CHRONI Mouls Examiner Physician/Medical Examiner the bunel-transit The lew requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown ٥ efter death. • Director: After this cartificate hes been signal of the funeral director, pege 2 should I 24b. Were eutopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Washing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral Di complately fillad in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cai 29a. Certifier \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) am 2000 Name and address of person who completed cause of death (Item 23a) (Type, Print) PAULMEHON IT WALDORFM 20602 ASHVINICUMAR 102

DHMH 16 Rev 6/95

State

Registrar

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2004

32. Resistrar's Signature

31. Date filed (Month, Dey, Year) MAY 13

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 AMEND ITEM #27 PER PHY 0831 5/25/04 JH Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 24, 2004 Year **Physician** 9:45 a.m. Darrell Chester Loughry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Neme (If not institution, give street and number) Examiner Grantsville Garrett Goodwill Mennonite Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 27, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1**™** M 2□ F Yrs. 79 Director 219-14-5802 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, The Medical Examinat must be netited at Grantsville Garrett MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21536 USA 4565 Chestnut Ridge Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0020 Specify white ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) WFRB Radio Station Owner/operator 12 th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nina Knox William Loughry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4565 Chestnut Ridge Rd., Grantsville, MD 21536 Donald O. Davis/friend 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pleasant Valley Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Apr 27, 2004 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service I Newman Funeral Homes, P.A., PO Box 275 Rumace 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretqry arrest, shock, or hear tail pre. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Cardiovascular disease /Medical Immediate Ceuse (Final disease or condition resulting in death) Atherosclerotic 2years Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) signed by the a 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown syndrome by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed certificate has b lirector, page 2 sl 1 - Yes 2 7/10 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Matural 2 Accident 1 ☐ Yes 2 ☐ No death. investigation ector: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier worrockthi 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Town Terrace Frostburg MD 21532 MD SHIN WONSOCK 31. Date filed (Month, 32. Registrar's Signature

front 1

**DHMH 16 Rev 6/95** 

State

Registrar

2004 6

	1- State of M Registrar	aryland / Department of Health at Certificate of Death	nd Mental Hygiene 2004 16
Physician /Medical Examiner	Decedent's Name (First, Middle, Last)     RIA HEDWIG      4a. Facility Name (If not institution, give street and number)		2. Date of Death Month Day Year May 12, 2004 4:30
Funeral Director	Frederick Memorial Host         5. Social Security Number       6. Sex       7. Ag         523-52-9516       1 □ M 2駅F         Usual Residence of Decedent	Spital Frederick ge (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours 71 Yrs.	Frederick  Hrs. 8. Date of Birth (Month, Day, Year)
the Maryland 28s-f show culfied at	10a. State 10b. County  Maryland Frederick  10e. Street and Number	10c. City, Town or Location  Frederick  10f. Zip Code	10d. Inside C
within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-f show the Madical Examiner must be notified at mpleted by Funeral Director	6904 Chokeberry Court  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Amed Forces' 1 1 Yes 2 Married 1 Yes, Give Year or Dates:	21703  Ever in U.S. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	United States  17 (Specify Yes or No- Puerto Rican, etc.)  10g. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White
	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Clerk	
ld be fill entat H ked ott Ic even	17. Father's Name (First, Middle, Last) (unobtainable) Grunewald	18. Mother: Elsi	Retail Name (First, Middle, Maiden Sumame) Fogel
and 2 fealth a m 27 is	19a. Informant's Name/Relationship (Type, Print)  Loren Lietha / Husband  20a. Method of Disposition	6904 Chokeberry Ct.	r Rural Route Number, City or Town, State, Zip Code) Frederick, MD 21703  Date 20c. Location - City or Town, State
permit Pages 1 Department of H Importent: If ite any injury or ot once.	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fun M Service Licensee	Resthaven Crematory  22. Name and Address of Facility Resthaven Funera	2004 Frederick, Marylan  L Services, Skkot Cody P.A.
Pnysician /Medical	23a. Part / Enter the disease, or complications that cause shock, or pear failure. List only operate on each limmediate Cause (Final disease or condition resulting in death)  Due to (or as	the death. Do not enter the mode of dving, such as ca	n. Hwy. Frederick, MD 21701 rdiac or respiratory arrest. Approximat Interval Bet Onset and I
eath certificate be executed at attending physician and for use as the burial-transit clan/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	a consequence of):  nc ( a new )  a consequence of):  licular lamph	4 42
requires that the death certifica een signed by the attending ph hould be detached for use as th hould by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day
w requires that been signed b should be dete leted by PI	Part II. Other significant conditions contributing to death b	out not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of d
The taw ate has b page 2 s	OF Western dead to reduce		24a. Was an autopsy findings prior to completion of cadeath?  1 Yes 2 No 1 Yes 2 No
ding Phys h. After this funeral dii	25. Was case referred to medical examiner?    Yes   2   No	ent 2 ER/Outpatient 3 DOA Other: 4 Nursi	Death Chack onl one  ng Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Medical Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home, farm, street, factory, office c. <i>(Specify)</i>	28f. Location (Street and Number or Rural Route Number of Rural Route Number Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of Rural Route Number of R
To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	one) 2 Medicer Examiner: On the basis of	aled.	occurred at the time, date and place, and due to the cause(s)
To To Cor	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)  2 C May 12, 2009
5	30. Name and address of person who completed cause of d	leath (Item 23a) (Type, Print)  501	2 c May 12, 2009 edent MD 21701

		1	For State Registrar AMFND TIFM #26	State of M	Maryland 331 5/25	d / Depa 5 <b>/04<sub>0</sub>#</b> /	artment o	f Health a of Death	and M		iene	04	16682
			Decedent's Name (First, Middle, Last							2. Date of Deat Month		Voor	3. Time of Death
	ysicia		Florence	Esther		MOREL	AND		:	April		Year 2004	5:30 P M
	/ledica amine		4a. Facility Name (If not institution, give		r)			n, or Location	of Death		4c. Count	y of Death	
			1318 Orendoff Re	oad					inge	r		Garr	ett
Fun	eral		5. Social Security Number 6. Se	x 7. A	kge (In yrs. la		If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	Con	place (State or Foreign intry)
Dire	ctor		236-04-2841	_ M 2 23.F	90	Yrs.				Nov. 30	, 1913	Ma	aryland
pu *		-	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					T	10d. Inside City Limits
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the A	He de	Director	MD Gar	rett			10f. Zip Cod	tinger		1	0g. Citizen of	What Cou	intry?
with a	4		1318 Orendorf R	oad				21522	2			TICA	
72 hours after death with the Maryland 72 hours after death with the Maryland natural, or Iteme 23a or 28e-f ehow	Se la	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S	S. 13. 1	Was Decedent			ecify Yes or No- Rican, etc.)			ican Indian,
fler	ing	들	1 Never Married 2 Married	Armed Forces						Hican, etc.)		ack, White	
iurs a	Exa	<u>چ</u>	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates	s:		1 □ Yes 2 🖾	No Specify:			Speci	<sup>ry:</sup> Wh	ite
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2 sh and ie m	other treumatic event,	1	19a. Informant's Name/Relationship (7							al Route Number		i, State, Zi	p Code)
E - 4	hert	-	John E. Moreland  20a. Method of Disposition	/Step_Som			BOX 4				26719 20c. Location	- City or T	own. State
5 8 5 E	5		1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	te Cé	emetery, crei	natory or other	place)					
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Dallimore, permit. Pages 1 a Department of Hec Importent: If Item	any in		21. Signature of Funeral Service Licen	Than I			Name and A		U	tewart I			е
4 403	8 0	-	23a. Part1. Enter the disease, or comp	The Court	od the death					Oakland		1550	Approximate
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ath certific	or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	23c. If yes, outcon	2 Fetal	death 3	∃Ectopic pregn ∃ Other (specif					ate of deliv	very Day Year
j 🖁 🖁	detached	lys!	9 Unknowh	9□ Unknown	1								
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I KECORDS, The law requires t	page 2	Completed									med? 2 No	Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of
VICAL P iicien: Th certificate	director,	Be	25. Was case referred to medical examiner?	Hospital:		2 10	रक्तार्थ ।	Other	113-	h (Check only or	Cateb		SSISIFD
_ \$ .9	ō	٥	1 Yes 2 No 27. Manner of Death	1 L Inpa		ER/Outpaties 28b. Time of	nt 3 DOA	Injury at		me 5 Residence 128d. Describe h	-	ther (Spec	LIVING
Attending a death.	funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of le (Month, I	Day Year)	Injury		Work? 1 ☐ Yes 2 ☐					
UIVISION  al or Attending after death. I Director: Afte	d in by the	Certification;	3 Suicide 6 Could not be determined	289. Place of	Injury - At ho etc. (Specify	ome, farm, st	reet, factory, of	fice		28f. Location (S City or Tow	treet and Nun n, State)	nber or Rui	ral Route Number,
UNIVISION OF To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th	stety fille	edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medicaf Exen	ysician: To the be niner: On the basis and manner	of examina	wledge, deat tion and/or in	h occurred at the	ne time, date a my opinion, de	nd place, ath occuri	and due to the c red at the time, d	ause(s) and n late and place	nanner as , and due	stated. to the cause(s)
To the	comp	Me	29b. Signature and title of certifier	1 /			29c. Li	cense number	,	2	29d. Date sign		, Day, Year)
			1 SOLB	and.	UN	NO	$D_i$	0034	12:	3/	04/26/	2004	
			30. Name and address of person who	completed cause	of death (Item	1 23a) (Type,	Print)				· · · · · · · · · · · · · · · · · · ·		
			Robin Rissell M				Grants	sville,	Md.	21536			
R	Sta egistr		31. Date filed (Month Pac Year) 8	2004 32. Regi	istrar's Signa	ture	Sand F	<u> </u>					

	t		1 - For State Registrar	State of Maryland		artment of rtificate of			giene Reg. No. 20	06 16683
. de	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Gerald Alfred     Alfred     A. Fecility Name (If not institution, give s	street and number)	•		or Location of De	2. Date of De. Month May eath		Deeth
	Funeral Director		033-20-1433		ast birthday) Yrs.	Takoma If Under 1 Yea Months Days	r If Under 24 F	lin. 8. Date of Birl (Month, Da		B. Birthplace (State or Foreign Country)
	he Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  Virginia Loudoun		Town or Lo	ille			10-02	10d. Inside City Limits 1 ☑ Yes 2 □ No
	with th	Dir	10e. Street and Number 38 South Loudoun St	treet		10f. Zip Code	180		10g. Citizen of Wh	of A.
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itams 23a or 28a-f show aumatic event, the Marical Examinating to Incitied at	by Funeral Directo		12. Was Decedent Ever in U.S Armed Forces? 1 LXYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ No		(Specify Yes or No uerto Rican, etc.)		American Indian, White, etc. White
21215-0	within 72 ho iene. than "natur tra Manical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life.	dent's Usual Occi kind of work don DO NOT use retir uty Comm	ed) most of		16b. Kind of Busin	ness/Industry Government
Maryland 2	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Alfred Melvin				Mildre	Name (First, Middle, ed Shermar	)	
	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is merke eny injury or other traumatic once.		Josephine Cecelia (20a. Method of Disposition	Nassef Melvin	38 S	outh Lou	doun Str	eet, Love		, VA 20180
altimore,	nit. Pages artment of P ortant: If ite injury or of		1 ☐ Burial 2 ☒Cremation 3 ☐R 14 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/☐sense	Metr	ropoli	osition (Name of matory or other pl tan Crem 2. Name and Add	atory '	May 20 2004	lexandri	a, Virginia
Ba	Depa Depa Impo eny is		Milliam 1	Managla	1			cle, SE, L	eesburg,	hapel, Inc. VA 20175
	Physician /Medical		23a. Pert1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ie cause on each line.	PVL lence of):	ner the mode of dy	ring, such as card	diac or respiratory a		Approximate Interval Between Onset and Death
100	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that stituted a portion	Due to (or as a consequence of the CLUSTRID	ience of):	NDRO	ME CLE CO	UTI		-2DAYS
3760,	cate be executed physician and the burial-transit	cal	that initiated events resulting in death) Last	Due to (or as a consequ						
.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2↓ No 9 □ Unknown	3c. If yes, outcome of pregnal 1 Live birth 2 Fetel 4 Pregnant at time of de	death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	
rds, P	w requires that been signed b should be deta	ρ	Part II. Other significent conditions con HYPERTENSION O	BSTRUCTINE S	ilting in the u	APMM,	DIAIS			ute to the cause of death?  Probably 4 Unknown
I Records,	The law re ate has bee page 2 sho	Completed	ATHAL FILLHUATI	GAITLO INTETI	NAL !	LIERY L	) LEASE		osy prio	ore autopsy findings available or to completion of cause of ath? ] Yes 2 □ No
S Egg	sician certific rector	Be c	25. Was case referred to medical examiner?	fospital:	ER/Outpatie	nt 3 DOA	ther	Death (Check only of g Home 5 ☐ Resid		(Conside)
0 ر	ng Phy ter this neral d	on: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o				now injury occurred	
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	M 1[	yes 2 □ No	28f. Location (S City or Tox		or Rural Route Number,
	To the Hospital within 24 hours : To the Funeral completely filled	edical		sician: To the best of my knowner: On the basis of examinat and manner stated.				ccurred at the time,	date and place, and	d due to the cause(s)
)	withi To t	M	29b. Signature and title of certifier	nsundan	<i></i>	D	5336 g	)		is, 2004
2	0		30. Name and address of person who co	ompleted cause of death (Item  7 PWN RUAD	23a) (Type.	Print) (5: 202,	GAIHER	spina, M	D: 20078	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signal		& So	Cu pro 8	•		

ORIGINAL

ian	Ragistrar  1. Decedent's Name (First, Middle,	Last)		Certificate of	Death	2. Date of Death		3. Time of Death	
		Myers, Sr.				Month May	76 200°	4 6:25 P	
ical ner	4a. Facility Name (If not institution,				or Location of Death		-		
	113 Sunflower  5. Social Security Number 6		n yrs. last birtho		agerstown	8. Date of Birth	County of Death   Washington		
	219-14-9923 Usual Residence of Decedent	1 M 2□F 7. Age ("	80 Yr	Months Days		Apr. 29, 1	924	Mary land	
_	10a. State 10b. County	10	C. City, Town	or Location					
Director		ngton		Hage	rstown	100	Citizen of What		
Ē	10e. Street and Number 113 Sunflower	Drive		101, 2ip 000e	21740	1.09.		-	
Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. Was Decedent of I	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No-			
by	1 Never Married 2XXXMarried		1943 <b>-</b> 1946	1 □ Yes 2XXVo					
eted	15. Decedent's (Specify only highest	Education grade completed)	(0	ecedent's Usual Occu Give kind of work done	during most of work	ing 16l	o. Kind of Busines	ss/Industry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT use retire			Petroleu	m Sales	
	8 17. Father's Name (First, Middle, La	ast)		Salesma		e (First, Middle, Mai		iii Jares	
To Be	Isaiah	Myers			Thelma	a Helena	Crabil	<u> </u>	
1	19a. Informant's Name/Relationship	p (Type, Print)	100						
1	Betty J. Myers 20a. Method of Disposition			3 Sunflower Disposition (Name of					
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	B □Removal from State	cemetery,	crematory or other pla	ice)		553		
	21. Signature of Funeral Service Li		Cedar L	awn Mem. P Osborne Mu			gerstown	SOUTH STATE OF THE	
	1: 7.					_ ·	liamenor		
ı	disease or condition resulting in death)	_a_Cardiac		ctr to					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of in 1 I I I onsequence of	nfarction				l day.	
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68460,

·			1 - For Stata Registrar	State of M	laryland		artment rtificate				lental Hy	_	Z U L		16685
			Decedent's Name (First, Middle, Last	)					Journ	1	2. Date of De	Reg. No	o		3. Time of Death
	Physici		Patricia	Dian	e	Mur	phy				Month May 1	2 , Da	y 2004	Year	10:40A M
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location of	of Death	riay 1		. County o	f Death	10:40A
	Lxaiiii	ici		orial H		al	Fred						Fred		ck
	Funeral		5. Social Security Number 6. Se.	x 7. A	ge (In yrs. las		If Under 1	Year	If Under	24 Hrs.	8. Date of Bir	th		9. Birthp	lace (State or Foreign
	Director		220-58-4465	M 20XF	51	Yrs.	Months	Days	Hours	Min.	May 27	y 19	52	Mary	Tand
	pu ,		Usual Residence of Decedent  10a, State 10b, County		10.00										
	aryla shov	<u>-</u>	Maryland Frederic	k	-	Town or Lo								1	0d. Inside City Limits 1 Yes 2 □ No
	he M	Director	,												
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "netural", or itema 23s or 28a-f show any figury or other traumatic event, I'm Medical Eraini at trias Le inclined at 2005s.	급	10e. Street and Number 117 Water Street	_			10f. Zip (					_	tizen of Wh S.A.	nat Cour	itry?
	na 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \			spanic Orie	gin? (Spe	cify Yes or No		14. Race	Americ	an Indian
(0	riter	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces	?						cify Yes or No Rican, etc.)		Black,	White,	etc.
ဗ္ဗ	al', o	by	3 XXidowed 4 □ Divorced	If Yes, Give Year or Dates:			I□Yes 🌡	Ø No	Specify:				Specify:	Wnıt	e
9	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	tent's Usual kind of work	Occupa	tion	ف ما بيمانا		16b. K	and of Bus	ness/Inc	dustry
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2	ygien ygien t,	Con	12			Sec	retar						asing		npany
lud	d oth	Be	17. Father's Name (First, Middle, Last)  Jerome F.	Habn Sr							(First, Middle, nor Mar			)	
Maryland 21215-0036	Men Marke Marke	ဥ			•										
Maj	d 2 st th and 7 ts n traun		19a. Informant's Name/Relationship (Ty Brian K. Hahn, Sr.								eld, PA		or Town, Si 7320	ate, Zip	Code)
o,	1 and Healt am 2		20a. Method of Disposition	, 5011	20b. Plac	on of Dieno	cition (Name	a of	1		ata	00. 1		ity or To	um Ctata
nor	ages nt of t: If it		14 Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	Rest	netery, cren naven	atory or oth	ler place	ndens	May 1	L7, 2004	Fr	ederi	ck.	MD
Baltimore,	artme ortan injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	ae I											
 	Departiment of the particular		▶ Richard E.	I very M	00255	1	.06 Ea	st	hurc	h St	PA Fur	leri	l Hom ck, M	e D 2	1701
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause ne cause on each I	d the death.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rest,			Approximate Interval Between
N.	Priysician		Immediate Cause (Final disease or condition	Diabetic	Ketoa	cidosis	5							i).	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):									I-KIR/AI
	Lxammer		Sequentially list conditions,	Acute V	ional tail									U	Known
	Si 9d	lne	cause. Enter Underlying Cause (Disease or injury	1	a conseque	٥.								1,,	
	and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as		ry Disci	175							V	nknown
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387	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal		i Trictor	Щ									- 0	NO IOWI \
×	eath certifi attending   I for use as	Physiclan/Me	IF FEMALE:	3c. If yes, outcome	of pregnanc	v							22d Date		71
. Box	atter I for u	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3 🗆	Ectopic pred						23d. Date ( Month		y Day Year
P.O.	res that the de signed by the a be detached t	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown											
 	s that	by Pl	Part II. Other significant conditions cor	tributing to death b	out not resulti	ng in the un	derlying cau	ise giver	n in Part I.		23e. Did to	bacco u	se contrib	ute to the	a cause of death?
Records,	w requires been sig should bo										1 🗆 1	es 2	□No 3	☐ Proba	ıbly 4 ⊠Unknown
000	s bee	olete									24a. Was	an	24b. We	re autop	sv findings available
Re	The lav ate has page 2	Completed									autop	med?	1 000	un?	sy findings available inpletion of cause of
Vita	ician: Th certificate rector, pag	o l	25. Was case referred to medical				·		26 Place	of Death	(Check only o	2 No	1	Yes :	2
>	ysicia is cert direct	To B	examiner?	ospital:	ent 2 EF	VOutpatient	3□ DOA	Other	100		e 5□Resid		6 Dother	(Specify	)
T Of	ding Phys		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28	Bb. Time of Injury	280	c. Injury	at		8d. Describe h			(,	
0	auth. or: Af	atic	2 Accident investigation	,	, ,	,,	М		es 2 🗆 N	10					
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At home	e, farm, stre	et, factory, o	office		2	8f. Location (S City or Tox	treet an π. State	d Number	or Rural	Route Number,
	ital o irs aft ral Di led ir			F											
	To the Hospital or Attending Physician: whim 24 hours after death as a first death To the Funeral Director. After this certifica completely filled in by the funeral director, it	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best ier: On the basis of and manner st	i examinatior	edge, death n and/or inv	occurred at estigation, in	the time my opi	e, date and nion, death	f place, ai h occurre	nd due to the o d at the time, o	ause(s) date and	and mann place, and	er as sta I due to	ited. the cause(s)
	Mithin Fo the	Me	29b. Signature and title of certifier				29c. l	License	number			29d. Dat	e signed (/	Aonth, D	ay, Year)
	. , , , ,		> SMENON, M.D.					000	5579	13			5 - 13		
	(D)		30. Name_and address of person who co	mpleted cause of o	leath (Item 2:	3a) (Type, F			_						,
	10			Hospital	Frederick	110	•		ourcsh	, K.	Monon,	M.D			
	₃ Sta		31 Date filed (Month, Day, Year)	32 Bogistr	ar's Signatur	^	_								
	Registr	ar	MAY 2 5	2004	Contract of	K	Come	15	*						

		_ FOr	epartment of Health and N Certificate of Death	Reg	3. No. 2004   66
Physici /Medio Examir	cal	ANDREA MARIE MUDD  4a. Facility Name (If not institution, give street and number)  8720 RED BAY RUN	4b. City, Town, or Location of Death BEL ALTON	MAY 15	, 2004 11:09  4c. County of Death CHARLES
uneral irector		5. Social Security Number  227−80−8773  Consider Security Number  227 −80 −8 773  Consider Security Number  6. Sex  1 □ M 2√√2 F  7. Age (In yrs. last birther)  50 Yr  Consider Security Number  1 □ M 2√√2 F  1 □ M 2√√2 F	day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) NOV • 9, 1	
8a-f show offilied at	Director	10a. State 10b. County 10c. City, Town of MARYLAND CHARLES	BEL ALTON	100	10d. Inside City Lim 1 □ Yes 2 🕅 g. Citizen of What Country?
23a or 2 ust be n	ral Dir	10e. Street and Number 8720 RED BAY RUN	10f. Zip Code 20611		U.S.A.
Department of need to whether hyperer in property of thems 23a or 28a-1 show important: If team 27 is marked other than "natural, or thems 23a or 28a-1 show any injury or other traumatic avent, the Mydical Examenar must be notified at once.	by Funeral	11. Marital Status  1 Never Married	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 25 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
r then "natu the Medical	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) IINISTRATIVE SECT	ring	Sb. Kind of Business/Industry  LAW FIRM
rked other	To Be C	17. Father's Name (First, Middle, Last) PAUL DARWIN OLIVER		e (First, Middle, Ma RUTH BC	
27 is mai			Mailing Address (Street and Number or Run 20 RED BAY RUN I		City or Town, State, Zip Code)  N, MD • 20611
ant: If Item		1 FTRurial 2 Compation 3 Demoval from State cometery,	or is position (Name of crematory or other place)		Oc. Location - City or Town, State  BEL ALTON, MARYLA
Imports any inj		21. Signature of Edneral Service Licensee MOO479  Michael D. Fr	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MARYLA	<u>IND 2064</u>	16
ysician Medical aminer		23a. Part 1. Enter the disease, or complications that caused the eath. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of	+ Cancer	or respiratory arres	st, Approximate Interval Between Onset and Death
ician and burial-transit	cal Examiner	Sequentially list conditions.  Tany leading 1s immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to for as a consequence of the control of t			
ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetel death 4   Pregnant at time of death 9   Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
s been signed by should be detac	b	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death
ite has	Completed			24a. Was an autopsy performe	
this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Other	h (Check only one) ome 5 Aesiden	) ice 6
within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	:uo	27. Manner of Death    Matural   5	ury Work? M 1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	eet and Number or Rural Route Number,
ours aft heral Di filled in	edical Cer	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only 2 Medical Examiner: On the basis of examination and			
within 24 h To the Fur completely		one) And manner stated.			

ORIGINAL

			For Stata Registrar	State of N	Maryland		rtment of H tificate of L		d Mental Hyg	iene 2004	16687
			1. Decedent's Name (First, Middle	, Last)					2. Date of Death	h Day Year	3. Time of Death
	Physicia /Medic		LaNeve			McCar	dless		MAY	10, 2004	8:20 P M
	Examin		4a. Facility Name (If not institution	, give street and numbe	er)		4b. City, Town, or	Location of De	eath	4c. County of Dea	th
			16244 Eylers	Valley Rd.				cmont		Freder	ick
	Funeral		5. Social Security Number		Age (In yrs. las		If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		529-32-5246	1 ☐ M 2KCKF	76	Yrs.			in. (Month, Day, Oct. 28.	1927 Ut.	ah
	pu ,	}	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	eation		-		10d. Inside City Limits
	anyla shov	-	Maryland Frede	orick		mont	Cation				1 Yes 2 No
	8a-f	ectc					1404 77 00 1			og. Citizen of What C	
	vith t	급	10e. Street and Number				10f. Zip Code	20	16		ountry?
	s 23s	ra	16244 Eylers Va		5	140.1	2178		V(C===#+ V====N==	USA 14. Race - Ame	ndoon ladion
	er de Item	ru Ru	11. Marital Status	12. Was Decede	s?	13. 1	Yes, specify Cuba	n, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)	Black, Whi	
36	s aff	Ϋ́	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes Give			☐ Yes 2 🙀 No	Specify:		Specify: W	hite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show ont, the Madical Examinar must be notified at	Completed by Funeral Director	15. Decedent		-	16a Decec	lent's Usual Occupa	ition		16b. Kind of Business	/Industry
15	n 72	Set	(Specify only highes	st grade completed)		(Give	kind of work done of OO NOT use retired	furing most of	working		
72	with ene. thar	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Вс	okkeeper			U.S Gove	rnment
0	be filed within 72 hours after death with the Marylan ald Hygiene. Id other than "natural", or items 23a or 28a-1 show over, the Madical Examiner must be notified at	0	17. Father's Name (First, Middle,	Last)				18. Mother's i	Name (First, Middle, M	Maiden Surname)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than sumatic event, the M.	To B	Rudger D. Smi	ith				De1	.1a	Richins	
J.	shound M	-	19a. Informant's Name/Relations			19b. Mailin	g Address (Street a	and Number of	Rural Route Number,	City or Town, State,	Zip Code)
ž	5 = Z =		Joyce McCandless	s/Daughter		16244	Eylers V	Valley	Rd. Thurmo	ont, MD 21	788
ē,	ges 1 an t of Heal if item 2 or other	Î	20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other place	a)	Date 2	20c. Location - City or	Town, State
Ę	Pages nent of I ant: If its arry or o		1√ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)		(O		Grove Cer		17, 2004	Pleasant (	Grove, Utah
Baltimore,	permit. Pages Department of Important: If i any injury or o	l i	21. Signature of Funeral Service					The second second second	tauffer Fu		
ã	Per Per Per Per Per Per Per Per Per Per	67	400 MC	Do-		16	21 Opossi	ımtown	Pike, Fred	erick, MD	21702
			23a. Parti. Briter the disease or shock, or heart failure. List	complications that caus	sed the death.	Do not ent	er the mode of dying	g, such as care	diac or respiratory arre	est,	Approximate Interval Between
	Fnysician		Immediate Cause (Final	omy one cause on each	- 1						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or		no of):	corcun	2000/			
	Examiner	Н									Imonth
	_	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseque	nce of):					
	d d ansit	Examiner	Cause (Disease or injury that initiated events	С							
ó	be executed sician and burial-transit	E	resulting in death) Last		as a conseque	nce of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical		d							
9	tifica ng ph as th		IS SENANCE.	Ti							
Вох	death certifica attending ph if for use as t	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1∏Live birth	me of pregnand 2  Fetal d		Ectopic pregnancy			23d. Date of de	•
	ie deat the att hed for	Sicie	in the past 12 months? 1 □ Yes 2 □ No		t at time of dea		Other (specify)			Month	Day Year
P.0	that the deed by the detached	Physician/Med	9 🗆 Unknown				0.100				
	signed d be det	by F	Part II. Other significant condition	ons contributing to death	h but not result	ing in the u	nderlying cause give	en in Part I.	-1 _	acco use contribute t	
p	v requir been si should I	ed	Coronary	artery	0120	ase			1  Ye	s 212No 3□P	robably 4 Unknown
Records,	aw re is be	Completed	Huperten	sign					24a. Was ar		utopsy findings available completion of cause of
æ	The lav	E							perform		
Vital	ician: The certificate rector, pag	Be C	25. Was case referred to medical	I				26. Place of	Death (Check only one	9)	
f <	Physician: r this certifica ral director, i	ToE	examiner? 1 ☐ Yes 2 No	Hospital: 1 🔲 Inpa	atient 2 ☐ El	R/Outpatien	t 3 DOA Othe	or: 4 🗆 Nursin	g Home 5 Reside	nce 6 □Other (Spe	ecify)
	ding Ph h. After th funeral		27. Manner of Death  1   Natural  5 □ Pendin	28a. Date of I	njury 2 Day Year) 2	8b. Time of	28c. Injury Work	at	28d. Describe ho	w injury occurred	
<u>i</u>	ath. or: Af	atic	2 Accident investig	gation				Yes 2□No			
Division	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	nined 289. Place of	Injury - At hom etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	rs aft at Di	Cer									
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		(Check only & Medical	ng Physician: To the be Examiner: On the basis	s of examinatio						
	the I hin 2- the F	Medical	one)	and manner							
	To To con	2	29b. Signature and title of certifie	Л			29c. License	1C 1	25	Ed. Date signed (Mont	in, Day, Todi/
,			J. N.				DS	1643		21,0109	
	6		30. Name and address of person	who completed cause of	of death (Item 2	23a) (Type.	Print)	-1	3	Frederica	k mD
			Shah Hiren	1 MU 6	5 C	1hc	mag	Jhon.	son Dr		21704
	Sta		31. Date filed (Month, Day, Year)	0	istrar's Signatu	ir⊎ ~	1 4				1
	Registi	al	mai 1	1 2 2 2 2 4 /2		5/20	STORES	1600			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:00 AM MAY 2004 16 NORMA HENRIETTA MCCANN /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S CHESTER 29D QUEEN MARY COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 X F 496-65-6000 Yrs. 1929 OHIO Director 74 15, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow rthen "natural", or itema 23a or 28a-f ehov Tre Medical Exeminer must be cutified at 1 ☐ Yes 2 ▼ No CHESTER Director QUEEN ANNE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21619 29D QUEEN MARY COURT Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. ACCOUNTING PAYROLL OFFICER 12 1 filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other treumatic event 2008: Be HENRIETTA STANECKI LLOYD HINKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 PEACHTREE ROAD, FALLSTON, MD 21047 SANDRA STOKES/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 05/19/2004 STEVENSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK RD., CHESTER, MD 21619 21. Signature of Funeral Service Licensee Reserve 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEART Immediate Cause (Final disease or condition resulting in death) PONGESTIYE **Physician** /Medical Due to (or as a consequence of): CARDIOMYOPATAT **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION 2 **N**0 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes been si Completed BIVENTRICULAR PACEMAKER 24a. Was an autopsy performed? 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 ☐ Yes X No Other: Certification: To 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation ours after death. nerel Director: A filled in by the fu 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö within 24 hours a To the Funerel I 29a. Certifier entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Pho Ch 29b. Signature and title of certifier 0044837 comodo 30. Name and address of person who completed cause of thath (Item 23a) (Type, Print) MEDICAL PARKWAY 2002 KENNESY JOHN 32. Registre's Signature 31. Date filed (Month, Day, Year) State Elen & Sperke Registrar

State of Maryland / Department of Health and Mental Hygiene 🛭 🕦 👢 16689 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Robert Davidson Muir May 07, 2004 11:09 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 MM 2□ F Yrs. 212-24-2351 Director 76 July 10, 1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. importent: if item 27 is marked other then "natural" ~ " any injury or other treumatic aven." 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Washington Street 21539 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ② No Specify δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John James Muir Mary Frazer Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Lee Muir-Wife 22 Washington Street, Longconing, Md. 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 10. 1 4 ☐ Donation 5 ☐ Other (Specify) Mountain ViewCemetery 2004 Moscow Mills Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 E. Main 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Priysician one Day /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 3 Ectopic pregnancy Year Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has performed' 2 110 1 Tyes 1 Yes 2 - No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ⊡ 1√0 1 ☐Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifie 5 IVA toes 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Day, Year, 32. Registrar's Signature State Registrar

Unpend Iter#23a,27,28a-f,PER ME,C831,5/27/0/eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Malcolm L.Mason 4-03156 State of Maryland / Department of Health and Mental Hygiene RPD 1 - For State Registrer Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** May 9, 2004 0816 A Malcolm L. Mason /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months **1**€ 2□ F Yrs. May 5 1971 Director 33 218-86-6238 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show in than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No Maryland Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? 20785 USA 1329 Nalley Terrace Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ģ 3 ☐ Widowed 4 🖾 X vorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within 7 t Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Johnson Cleaning 12th0 Cleaning Service other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental H Is marked of James Mason Veronica Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If item 27 Is eny injury or other trau QDG. 1912 E. Copeland St. Annapolis, Md. 2. of Disposition (Name of Date 20c. Location City or Town, State Michele Taylor (Sister) 21401 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
BEstgate Memorial 20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 5/18/04 Annapolis, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wm. Reese & Sons MOrtuary, 821 West St. Annapolis, Md. Lavry B. Ree se 1100483 23a. Part1. Enter the illisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Narcotic (heroin) and alcohol intoxication **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit Due to (or as a consequence of): attending physician for use as the burian 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death ed by the a P.O. 9□ Unknown signed t d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Division 5 Pending investigation or Attending 1 Natural death. 5/9/04 1 Yes 2 No 2 Accident unknown Director: 6 X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1912 Copeland St., Annapolis, MD residence within 24 hours a To the Funerel L Hospitel 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat May 10, 2004 O.C.M.E. completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 ddress of person wh LOCK

Registrar

State

31. Date filed (Month, Day, Year,

strar's Signature

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 23,2004 3:52 A February Charles McCarthy Daniel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 27 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 74 189-20-2056 Dec. 1929 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show rai, or itams 23a or 28a-f shov Examiner must be notified at 1 Yes 2XXVo Directo Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2767 Loch Haven Drive 21754 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other trainmant. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: Specify: 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Supervisor Internal Revenue Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel McCarthy Sarah Hockenberry 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan P. Shenos, daughter 2767 Loch Haven Drive, Ijamsville, MD 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Cathedral Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 2/26/2004 Scranton, Pennsylvania 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licensee M00999 | 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jubdurgi Physician hematam 6 Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in incurate cause. Enter Underlying Cause (Disease or injury CENTIFICATION APPROVED BY MAJOCH EXMINER Due to (or se a noneequance of) Examiner The taw requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes DISPOSE Completed Parkinson 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? rohn DISTANT has autopsy performed? 1 Yes 2 No Anemia certificate 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: After Injury 1 Natural 5 Pending Fell at 1 Yes 2 No home investigation death. 330 2 Accident 3 ☐ Suicide 154 after death in by the f 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 2767 Loch Haden Dr. Town determined 4 Homicide IJamsville Hame within 24 hours a To the Funeral I At Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ç 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Shah Hiron MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 65 Thonson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 4 2004 Registrar

		1 – For State Registrar	State of Maryla	-	artment of H			iene <sub>eg. No.</sub> 2004	16693
		Decedent's Name (First, Middle, Last	st)				2. Oate of Deat	h	3. Time of Death
Physici		Lillian A	mabel N	log1e			May 8,	2004 Year	4:43А.м
/Medio Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or		h	4c. County of Death	
		Washington County	Hospital		Hagers			Washingto	n
Funeral Director		5. Social Security Number 6. S 217-01-9061	ex	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		9. Birth 1, 1916 Mar	place (State or Foreign ntry) yland
pug M		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
daryli f sho	5	Maryland Frederic		Thurmo					1 TYes 2 □ No
the 7	rect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	ntry?
h with	alD	218 Crestview Dr	ive		21788			USA	
ine, mally latter ZIZIOCOOO s 1 and 2 should be filed within 72 hours atter death with the Maryland if health and Mental Hygiene. item 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, the Maddial Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  \$\frac{1}{3}\text{Vidowed} 4  Divorced	12. Was Decedent Ever ir Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21☐ No	ispanic Origin? (S in, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
2 hou	ted	15. Decedent's Ec (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation	rking	16b. Kind of Business/In	dustry
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	n)	ining	O II-	
tygier her th		17. Father's Name (First, Middle, Last)		Н	omemaker	19 Mothods No.	me (First, Middle, A	Own Ho	me
ally allowed the standard within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event.	Be			baugh		Dorot		naiden Sumame)	
al yid should ind Men ind Men ind marke umartic	ဥ	19a. Informant's Name/Relationship (			ng Address (Street a	and Number or Ri	ural Route Number,	City or Town, State, Zip	Code)
and 2: and 2: ealth ar n 27 is		James Nogle/Son		218 C	restview	Drive, T	hurmont,	MD 21788	
ss 1 a of Her item		20a. Method of Disposition	1	. Place of Dispo	osition (Name of matory or other place	θ)	Date 2	20c. Location - City or To	own, State
Pages ment of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify			e Cemeter	-		Thurmont, M	
Dattillore, IVI		21. Signature of Fuperal Service Licer	isee .					uneralNome, nt, MD 2178	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	eath. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	. Athrosch	enosco					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	- 77				
Lxammer	ĕ	Sequentially list conditions,	b. Succession by Due to (or as a cons	cande	myogathy				
nstt	all I	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (01 00 2 00 10		0 1	1		1	
execu n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
icate be executed physician and sthe burial-transit	dlcal		_ d						
rtifica ng ph	Med	IF FEMALÉ:							
ath ce	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 F	etal death 3	☐Ectopic pregnancy			23d. Date of delive Month	Day Year
that the death certificated by the attending ped by the attending pedetached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time o 9☐ Unknown	of death 5L	Other (specify)				
that the ed by		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?
w requires that is been signed be should be det	d by						1 <b>☐ Y</b> e	s 2⊡No 3□Prob	ably 4 Unknown
w red s been shou	Completed						24a. Was ar	24b. Were auto	psy findings available
The la The la te has	E O						autopsy perform 1 ☐ Yes 2	y prior to co ned? death? ☑No 1 ☐ Yes	mpletion of cause of 2□ No
lan: rtifica	0	25. Was case referred to medical				26. Place of Dea	ath (Check only one		20.110
hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 ☐ No		ER/Outpatier		4 Livursing F	fome 5 ☐ Reside	nce 6 □Other (Specif	<i>y</i> )
nding Plath.	ation:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	/at ⟨? Yes 2 □No	28d. Describe ho	w injury occurred	
of or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecity)	reet, factory, office		28f. Location (Str City or Town	eet and Number or Rura , State)	l Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: Attent his certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C		ysician: To the best of my lining: On the basis of exam and manner stated.						
To th within To th compl	Me	29b. Signature and title of certifier	, //	1	29c. License	,		d. Date signed (Month,	/
		Lugene 15	· Casaga	mele	_ D 4	10307	MO	10 May C	4
1X		30. Name and a rress of person who	completed cause of eath (I	Item 23a) (Type,	Print)	*-		- /	
X		Dr. Eugene B	. Casagrande		possumtow	n Pike,	Frederic	k, MD 21702	
Sta Registr		31. Date filed (Month, Day, Year)	3 ZUU4 D	gnature	19 40	ocks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMENDED#25,27,28A-FperME FCHOPertificate of DeathKS Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 5:00 A<sup>M</sup> January 30, 2004 Florence Hinchen Nielsen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sunrise Assisted Living Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 TF Yrs. 472-32-6416 85 Sept. 16,1918 New Jersev Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Count 28a-f show r itams 23s or 28s-f shov 1XXYes 2 □ No Directo Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 990 Waterford Drive 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced 'naturai' 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Compl College (1-4or 5+) Elementary/Secondary (0-12) 5+ Health Care Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if itam 27 ia marked oth any injury or other treumatic event 2008: John Hinchen Elizabeth Fahey ္င 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Nielsen / Son P.O. Box 1299 Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan. 31, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 200421. Signature of Furieral Service Li Resthaven Funeral Services, Skkot Cody P.A <u>9501 Catoctin Mtn. Hwy. Frederick, MD 21701</u> 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician a Lung Cancer Months resulting in death) /Medical Due to (or as a consequence of): CENTRATION POSCUED BY NEOCCH EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ysician and le burial-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the ρh IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No o 9☐ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1XXYes 2 No 3 Probably 4 Unknown Recent hip Fracture, Hypertension 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Osteoporosis 1 Yes 2XXNo Division of Vital To the Hospitel or Attanding Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 SOther (Specify) ASSISTED Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 27 No ٩ After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Facility 5 Pending 1 KNatural 1 ☐ Yes 2 🔼 No death. investigation November 13,2003 6:00A 2XXxccident Unwitnessed fall within 24 hours after deat To the Funaral Diractor; completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Assisted Living Facility 990Waterford Dr. Frederick,MD 1X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) white 22(4) D 35183 Jan. 30, 2004

DHMH 17 Rev 1/2001

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Registrar

23 part 11

32. Registrar's Signature

Ali J. Afrookten, M.D. 300 West 9th Street; Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

			For State Registrar				and / Depa		t of H	ealth a		lental Hy	Reg. No.	2001	-	695
級	Physicia	an	1. Decedent's Name (First, N ROSEMARY HA			OMR						2. Date of De. Month MAY	Day 15	2004	3. Time of 1	P <sup>M</sup>
* • ****	/Medic		4a. Facility Name (If not instit					4b. City,	Town, or	Location of	of Death	MAI		unty of Death		
	Examin	er	JOHN B. PARS			,		SALI	SBU	RY			WIC	COMICO		
	uneral irector		5. Social Security Number 456–28–3733	6. Se		7. Age (In ye	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da MAY 24,	th y, Year) 1919	9. Birth Cou T	place (State or intry) EXAS	r Foreign
land	M H	-	Usual Residence of Deceder  10a. State 10b. Co		-	10c.	City, Town or Lo	ocation							10d. Inside Cit	y Limits
Mary	de de de	to	MD MON	COME	<b>RY</b>	K	ENSINGTO	ON							1 🗆 Yes	2 X No
th the	or 28g	Director	10e. Street and Number					10f. Zip	Code				-	of What Co	untry?	
ath w	23a	rai	4019 SIMMS	DRIVE					2089				USA	D A	inna lautan	
1 Z 1 3-UU30 within 72 hours after death with the Maryland	marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2  3 Wildowed 4 Divo		Armed F	2 📉 No ive	1	Was Deced If Yes, spec 1 ☐ Yes				ecify Yes or No Rican, etc.)		Race - Amer Black, White ecify: WH	, etc.	
2 P-0	habit	eted	15. Deci (Specify only h	dent's Edi	ucation le completed	)	(Give	dent's Usua kind of wo	rk done d	during mos	t of work	ing	16b. Kind	of Business/I	ndustry	
T ug	e Ma	Completed	Elementary/Secondary (0-			(1-4or 5+)	ART	DO NOT US	se retired	)			ART			
A belied y	in the		12 17. Father's Name (First, Mic	dle, Last)	4		ANI	LOI		18. Mothe	er's Name	e (First, Middle,		тате)		
Maryland 21215-0036 d 2 should be filed within 72 hours af th and Montal Hydiene	arked o	To Be	ROBERT HATC	HETT								DICKIN		.,		
			19a. Informant's Name/Rela ELLIOTT NEW		ype, Print)		1	•				INGTON,		own, State, Z 20895	ip Code)	
5 - 2 E	etto etho		20a. Method of Disposition			i	p. Place of Disponentary, cre	osition (Nar.	ne of ther plac	e)	t	Date	20c. Locat	ion - City or T	Town, State	
Pages	nt: If		1 ☐ Burial 2 <b>X</b> Crema  1 ☐ Donation 5 ☐ Other			State CF	ESAPEAR	-			5/17	/2004	STEVE	NSVILL	E, MD	
Baltimore, permit. Pages 1 a	Important: If Item 27 is any injury or other tra		21. Signature of Funeral Ser	vice Licens	500		F)	2. Name an ELLOW: 06 SHZ	d Addres	s of Facility ELFEN CK RD	BEIN ., C	& NEWN HESTER,	AM FUI MD 2	NERAL 1 21619	HOME, P	.A.
/60, te be executed XX	Asician and ledical aminer parish transit	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	b. Due to	o (or as a cons	sequence of):	in ler								
P.O. BOX 68 het the death certifical	y the attending phy ched for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	t	1 Live	utcome of pre birth 2 F gnant at time on	etal death 3	⊒Ectopic pi ⊒ Other (sp					23d	. Date of deli Month		/ear
	n signed by the a lid be detached f		Part II. Other significant co	nditions co	entributing to	death but not	resulting in the t	underlying o	ause give	en in Part I			obacco use Yes 2 □ N		the cause of do	
DIVISION OF VITAL RECORDS, P.O. to Attending Physician: The law requires that the	ate has been si page 2 should b	Completed										24a. Was autoj perfo 1 Yes		prior to death?	topsy findings a completion of ca 2 No	available ause of
/ITa	certificate rector, pag	Be	25. Was case referred to me examiner?	dical	Hospital:				Oth		of Deat	h (Check only o	one)	/	15555	£
ON OT VITAL	fter this c funeral dire	ion; To	The state of the s	ending vestigation	28a. Date (Mo		2 ER/Outpatie 28b. Time of Injury		8c. Injun	y at		ome 5 Resi		Other (Spec	かしい	rax
DIVISION It or Attending	within 24 routs aim obsur. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification;	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Plac	ce of Injury - A ding, etc. (Sp.	At home, farm, si ecify)	treet, factor	y, office			28f. Location ( City or To		lumber or Ru	ral Route Numi	ber,
Hospital	Funeral I	edical C			iner: On the		knowledge, dea nination and/or in									)
To the	o the	Mec	29b. Signature and title of c	ertifier	u., g 111d	o.u.tou.		290	c. Licens	e number			29d. Date s	igned (Month	, Day, Year)	
) i	s i o		N-fan						14	709	4		57	17/04		
ni	<b>×</b>				completed car	use of death (	Item 23a) (Type	Print)				512151			4804	
	Sta Regist		30. Name and address of period of the second	(Y") 1 '	7 20042	Registar's Si	ignature &	Spec	W							

			1 - For State Registrar			and / Depa	artment of F	lealth and	Mental Hy			16696
ľ	Physic		1. Decedent's Name (First, Middle, Genevieve F. Po.	-					2. Date of De Month	ath Day	Yeer	3. Time of Death
	/Medi Examii		4a Fasilis Name (If not institution of WMHS Memorical Ca		ber)		4b. City, Town, o	r Location of Dea	MAY 07	4c.	04 County of Deel LEGANY	04:30 a."
260	Funeral Director		5. Social Security Number  166 ~ 26 ~ 2395  Usuel Residence of Decedent	Sex	7. Age (In y 89	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Yeer)	9. Bin Mar	thplace (State or Foreign buntry) YLand
	Maryland e-f show	ctor	10a. State  MD  10b. County  Allega	ny	10c.	City, Town or Lo						10d. Inside City Limits 1 XYes 2 □ No
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Number  1 Baltimore Str	eet			10f. Zip Code 21502			10g. Citiz	en of Whal Co	ountry?
980	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be multipled at 2005.	by	11. Marital Status  1 □ Never Married 2 □ Married 3 □ XVidowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 1 If Yes, Give Year or Da	es? ZXNio		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? ( In, Mexican, Puel Specify:	Specify Yes or No rto Rican, etc.)	- 1	4. Race - Ame Black, White	
Maryland 21215-0036	within 72 ho ene. than "natur he Wedical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-	4or 5+)	16a. Dece (Give life. Teach	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking		nd of Business/	
land 2	should be filed nd Mental Hygis marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, La Franklin Fries	st)		reach		18. Mother's Na Elva Co	me (First, Middle, DOK			y School
, Man	and 2 sho eith and I 27 is ma ar treuma		19a. Informant's Name/Relationship Anne Little/Daug	(Type, Print) Iter		19b. Mailir 7066	ng Address (Street S Spruce S	and Number or R St., LaVo	ural Route Number	r, City or 21502	Town, State, 2	(ip Code)
Baltimore,	Peges 1 cment of He ant: If Item ury or oth		20a. Method of Disposition 1 ABurial 2 Cremation 3 14 Donation 5 Other (Spec		tate	Place of Dispo cemetery, crer corter C	natory or other place	May1	ation - City or Iman, PA			
Ball	permit. Departn Importa any injt		21. Signature of Funeral Service Lic	4. Zeio	ler		. Name and Address 69 Claren	,	Harvey H. Hundman.	Zei PA	gler F. 15545	.н.
760,	Physician /Medical Examiner	lical Examiner	23a. Park Enter the disease, or coshick, othean failure. List on Immedia Lause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate ease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. PNELMO Due to (o  b. RENAL Due to (o	ONIA r as a cons TUBUL r as a cons	equence of):	er the mode of dyin		c or respiratory an	rest,		Approximate Interval Between Onset and Death DAYS
P.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 V No 9 □ Unknown	23c. If yes, outco 1 □ Live birl 4 □ Pregna 9 □ Unknow	h 2 ∏ Fe ntattime of	ital death 3	Ectopic pregnancy Other (specify)			23	3d. Date of delined Month	very Day Year
ords, P	w requires that been signed b should be deta	ed by Pr	Part II. Other significant conditions GASTROINTESTINAL					n in Part I.	23e. Did to			the cause of death?
Vital Records,	Physicien: The law r this certificate has be al director, page 2 sh		RENAL FAILURE		,				24a. Was a autops perfor 1 Yes	sy _	24b. Were aut prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
Ion of VII	After uner	To B	25. Was case referred to medical examiner?  1	28a. Date of (Month,		ER/Outpatient 28b. Time of Injury	26. Place of Death (Check only one)  ent 3 DOA Cther: 4 Nursing Home 5 Residence 6 of 28c. Injury at 28d. Describe how injury oc					i(y)
DIVISION	ital or Attend	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide d Termine	286. Place o	Injury - At I, etc. <i>(Spe</i> c	home, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and . n, State)	Number or Rui	al Route Number,
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	Medical	one)	hysician: To the b miner: On the bas and manne	is of examir	nowledge, death nation and/or inv	estigation, in my op	inion, death occu	rred at the time, d	ate and p	lace, and due t	o the cause(s)
	5/10		29b. Signature and title of certifier	~ (0	eke		29c. License D00544			9d. Date AY	signed (Month, $f$	Day, Year)
	カル」 Sta	te	30. Name and address of person who Beverly Calkins N 31. Date filed (Month, Day, Year)	I.D. 500 1		ial Aver	ue Cumbe	rland, M	aryland	2150	2	
	Registr	ar	MAY 1 1 2004	Jene		W place	outs					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month May 2004 **Physician** Proctor 9, 7:00P Jeanette Frances /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charles Civista Medical Center LaPlata If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) May 12, 19 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1□M **XX**F 61 Yrs. 1942 Maryland 213-40-5119 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examinar must be notified at 1X Yes 2 No Director Maryland Charles Pomfret 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20675 USA 5300 Robert Lee Place or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Meat Wrapper Safeway 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Neal Harley 0 Walter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 5300 Robert Lee Place Pomfret, Maryland 20675 Oscar Proctor Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. May 12, 2004 Pomfret, Maryland St. Josephs Ch Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Offer Loussa Adams Funeral Home P.A. Aquasco, Maryland MO1323 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner rsician and e burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 100 1 ☐ Yes 2 ☐ No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes/ 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 UNatural death. 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) tilled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifieg D-21031

Maryland 21215-0036

Proctor

eanette Baltimore,

P.O. Box 68760,

Records.

Division of Vital

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Michael Leatherwood MD 12070 Old Line Ctr Ste 202 Waldorf,

MD 20602

			State of Maryland / Department / Department / Depart			ene g. No. 2004	16600
		city.	1. Decedent's Name (First, Middle, Last)	M'odio o o odio	2. Date of Death	1	3. Time of Death
7.	Physicia /Medic	al	JUDY MAE ROGERS		4/21/04	Day Year	6:15 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE S HOSPITAL	4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEO	RGE'S
100	Funeral Director		5. Social Security Number  6. Sex 1 M 2⊠ F  7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Dey, MAY 2,	Yeer) 9. Birth Cou. 1961 MARY	place (Stete or Foreign http) LAND
W	yland now at		Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Lo	cation			Od. Inside City Limits
	e Maria-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa-fa	Director	MD PRINCE GEORGE'S MARLOW	HEIGHTS			1 X Yes 2 ☐ No
	h with th	al Dire	10e. Street and Number 3380 CURTIS DRIVE # 302	10f. Zip Code 20746		lg. Citizen of What Cou J.S.A.	ntry?
980	72 hours after death with the Maryland natural; or Items 23s or 28s-f show digal Examiner trant be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 XNo	Was Decedent of Hispanic Origin? (Spr II Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2€ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: B	
21215-0036	within ene. than	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	6b. Kind of Business/In GOVERNMENT	dustry
d 2	Hyg the int,	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name			***
ylar		To B	MAURIE BARNETT		ROBINSON		
Maryland	ha re			ng Address <i>(Street and Number or Rura</i> FRANKLIN GIBSON R			
	1 al Hea		20a. Method of Disposition 20b. Place of Dispo	and the second s	-	Oc. Location - City or To	
Baltimore,	Pages ment of lent: If It		'4 Donation 5 Other (Specify) Resurrec	tion Ceme. 4/27/	/04 (	CLINTON, MAR	YLAND
Ball	permit. Pag Department Importent: I any injury o			2. Name and Address of Facility J. 7474 LANDOVER ROAD		INS FUNERAL ER, MARYLAN	
	189 ·		23a. Part 1. Errer the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac of	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or aska consequence of):	I weed			
*	Examiner		Sequentially list conditions b. Subarachy	oid bleed			
	pe pist	niner	if any, leading to immediate cause. Enter Underlying Cause (Olsease or injury	· lana lad	Poli.		
ć	ate be executed hysician and the burial-transit	Examiner	that inflated events c. Due to (or as a consequence of):	amonary em	0,44		
8760		dlcal	d				
Box 6	The law requires that the death certific ate has been signed by the attending proage 2 should be detached for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
ds, P.O	uires that the signed by Id be detac	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part 1.		acco use contribute to t	
of Vital Records,		Completed	chesty	1	24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
Vita	Physician: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death			
of	g Phys er this heral dii	n: To	1 ☐ Yes 2 No Position 1 X Inpatient 2 ☐ ER/Outpatier  27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury  1 ★ Natural 5 ☐ Pending	11 3 DOA 4 INdistrig Ho	me 5 ☐ Hesider 28d. Describe hov	nce 6 Other (Special winjury occurred	γ)
Division	tendin leath. lor: Aft the fur	catlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	001 1 (01-	and and North area De-	-10 11
DIV	s after of bit by ad in by	Certification;	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 See. Place of Injury - At home, farm, strength of the building, etc. (Specify)	eet, factory, office	City or Town,	eet and Number or Run State)	ar noute Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cared at the time, da	use(s) and manner as s te and place, and due t	stated. the cause(s)
	To t To th	M	29b. Signature and tyle of certifier A. M. M. M. D.	29c. License number D 45341	29	d. Date signed (Month,	( 200 ¥
2	(8)		30. Name and address of person who completed cause of death (Item 23a) (Type.  Tames Akras Prince	Print George Point	al Ch	everly (	MD
	Sta Regist		31. Date liled (Month, Day, Year)  APR 2 8 2004  Registrar's Signature	w			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. AMEND TIEM #21 PER DVR C831 5/25/04 JH 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last, Month 04 **Physician** 6:05 AM Bel1 Rudisil1 Laler /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Prince George Future Care Pineview Nursing Home Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months 1 M X F Deys Hours 94 240-24-7986 05 10 09 Director Cleveland Co Usuel Residence of Decedent N.C. the Marylend 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Completed by Funeral Director Clinton **Prince George** 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code e filed within 72 hours efter death with I si Hygiene. other than "naturel", or Itams 23a or ? 20735 9510 Atom Road USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Merried 2 ☐ Married I ☐ Yes 2 X No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5 Yrs. Farmer Farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) .. Peges 1 and 2 should be fill tment of Health end Mentei Hy tant: If item 27 is markad oth Addie **Blanton** John Eskridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health e important: if item 27 is any Injury or other trate page. 9510 Atom Road, Clinton, Maryland 20735 Pratt Mrs. Evelyn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Green Bethel Church 4/17/04Boiling Springs, N.C 4 ☐ Donetion 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee / DIRECLER Enloe Mortuary, Inc. Shelby, N.C. 231 N.Lafayette Street 28150 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Physiclan/Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last es tha burial-trer attending physician and Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? After this certificate has been signed by the a funerel director, page 2 should be datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en eutopsy performed? 1□Yee 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Diractor: After to in by the funere Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident r death 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours To the Funeral I complately filled 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat e end title of certif 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar LAXMI N BERWA FUTURE CARE NURSING HOME CLINION MD

32. Registrer's Signeture

31. Date filed (Month, Day, Year)

MAY 2 5 2004

			For State Registrar		State of	Marylar	nd / Depa <i>Ce</i>	artmen <i>rtificat</i>	t of H e of I	lealth a Death	and M		gien Reg. N	/ 11	104	16	700
	D:		1. Decedent's Name (First, Mide	de, La	st)							2. Date of De	aath			3. Time	of Death
	Physici /Media		Russell W.	Ι	Ray							Month Ma	y Ør		Year 2004	1:5	7 p M
	Examir		4a. Facility Name (If not instituti	on give	street and numb Medica.	Cen	ter	4b. City,	Town, or	Location o	of Death	n	40		y of Death Balt	imor	
	Funeral		5. Social Security Number	6. S		Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	-)	9. Birth	place (State	or Foreign
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	bu *		Usual Residence of Decedent 10a. State 10b. Count	v		10c Cit	ty, Town or Lo	ocation								10d. Inside	City Limite
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93	urs a	ğ	3 ☐ Widowed 4 ☐ Divorce		If Vac Giva	es: WWI	I	1 Yes	2₩ No	Specify:		7.		Specif	y: Wh	ite	
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	is 1 and 2 of Health of item 27 i		Frances S. Ray		Wife		5702			d Mo		Airy, l	Mary	1and	1 217	71	
altimore,	ges 1 of H if ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 □	Removal from St		Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place	θ)	May	11,	20c. L	ocation -	· City or To	own, State	
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г			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r comp	olications that cau	sed the deat	h. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approxima Interval Be	ate
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	/Medical		resulting in death)		a	as a conseq									111	inut	62
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9		Physician/Me	IF FEMALE:	T	23c. If yes, outco	ma of							T				
Вох	that the death certifii ad by the attending I detached for use as	ian	23b. Was decedent pregnant in the past 12 months?		1 ☐ Live birth	1 2 ☐ Feta	Ideath 3□	Ectopic pre						23d. Dat Mor	te of delive inth	,	Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 □ Pregnan 9 □ Unknow	t at time of d n	eatn 5∟	Other (spe	ecify)							Juj	
	that the	P	Part II. Other significant condit	ions co	ontributing to deat	h but not res	ulting in the ur	nderlying ca	usa awa	n in Part I		23a Did to	ahacco i	usa cont	ributa ta th	e cause of	dooth?
ds,	signad b	d b	Atheroscler					idonying oc	1450 9110	., ., .		1 🗆 Y		No.		ably 4	
ö	w requir been si should	ete										-		1			
Vital Records,	a S C	Completed by	Hypertensio	n								24a. Was		l p	Were autoporior to con death?	psy findings apletion of a	available cause of
<u>a</u>												1 Yes		1		2□ No	
⋚	Physician: this certificatal director,	Be C	25. Was case referred to medical examiner?	_	Hospital: V	-			Othe			(Chéck only o					
ō	Phys rathis ral di	5	1 ☐ Yes 2 No 27. Manner of Death	-	Hospital: 1X Inp 28a. Late of I		ER/Outpatien 28b. Time of		^	4 🗀 1401		ne 5 Resid				')	
0	ding h. h. After funer	ţ	1 Natural 5 ☐ Pendi	ng igation		Day Year)	Injury	M	Bc. Injury Work	ai 'es 2.∐N		od. Describe is	iow mjur	y occurr	ea		
Division of	l or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be	28e, Place of	Injury - At ho	ome, farm, stre			00 201		8f. Location (S	Street an	d Numb	er or Rura	Poute Nun	nhor
<u>S</u>	l or after after Dire	erti	4 ☐ Homicide determ	mnea	building,	etc. (Specify	y)	ot, taolory,	OITIO		- 11 -	City or Tow			or or riura.	HODIO NON	IDer,
-	Hospital 4 hours Funeral tely filled		29a. Certifier 1 Certifyi	ng Ph	/sician: To the be	est of my kno	wiedge, death	occurred a	it the time	e. date and	place a	nd due to the	Cause(e)	and ma	nner as ct	ated	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral	Medical	(Check only 2 Medical one)	Exam	iner: On the basi and manner	s or examina	tion and/or inv	estigation,	in my op	inion, deat	h occurre	d at the time, o	dato and	place, a	and due to	the cause(	s)
	To the within 2 To the complat	Me	29b. Signature and title of certific	er /	) .			29c.	License	number					(Month, L		
	. , , ,		Varia A	15	raher	MO		D	005	1852					120		
			30. Name and address of person	who o	ompleted cause of	of death (Item	23a) (Type I										
,	20+1	İ	David A. Brin						iva	Tour	505	Mary	1	m	4 (2000)		
	Sta	te	31. Date filed (Month, Day, Year		32. Regi	strar's Signa	ture					net. A	TGU	CI iii	1-1/14		
	Registra	ar	M	Y	1 3 2004	Ser	eve	Ø	, Co	port	2						

			1 - For Registrar AMEND ITEM #20				rtment of H		nd Mental I	Hygiei Reg.	2001	16701
			Decedent's Name (First, Middle, Last				1704		2. Date of Month	Death	5.a. U	3. Time of Death
-	.Physici /Medic		Helen Grace Tru			1			May		Day Year 1 200	
F	Examin	er	4a. Facility Name (If not institution, give Washington Count		*		4b. City, Town, or Hagersto		Death		4c. County of Dec	ton County
	Funeral	-	5. Social Security Number 6. Se		Age (In yrs. last bir	thday)	If Under 1 Year	If Under 24		Birth	9 Bit	rthplece (Stete or Foreign
4	Director		214-09-2045	□ M 2 💢 F	92	Yrs.	Months Days	Hours		Day, Ye		aryland
T areas	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	Mary -f •hc	tor	Maryland Washing	ton	Hager	rsto	wn					1 □ Yes X□ No
	or 286	lrec	Maryland Washing 10e. Street and Number	LOII			10f. Zip Code			10g.	Citizen of What C	ountry?
	ath w	ral	18716 Rolling Rd.				21742				J.S.A.	
920	n 72 hours after death with the Maryland *natural', or Itama 23a or 28e-f ehow salical Examiner mast be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? XNo		Vas Decedent of His Yes, specify Cubar ☐ Yes 2월 No	spanic Origii n, Mexican, I Specity:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Whi	
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a.	Deced (Give	ent's Usual Occupa	ition	of working	16b	. Kind of Business	/Industry
121	-	mpl	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. E	O NOT use retired)					
<b>d</b> 2	a tyce		17. Father's Name (First, Middle, Last)			Ma	nager	18. Mother's	s Name (First, Mid	Idle, Maid	Toy Sto	re
lan	Q 22 20 9	To Be	Clyde Otho Trumpor	wer Sr.				Edi	th Hose			
Maryland 21215-0036	and and mum		19a. Informant's Name/Relationship (7)	ype, Print)	19b	. Mailin	g Address (Street a	nd Number	or Rural Route Nu	mber, Cit	y or Town, State,	Zip Code)
d)	l an Heal		Ravenna June Hoo	over/Daug			9 B Winds	sor Ci	rcle Hage			land 21742
Baltimore,	permit. Peges 'Department of the Important: If its any injury or of once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)		te cemeter	ry, crem	atory or other place			5000	Location - City or	
altir	mit. Poartme		21. Signature of Funeral Service Licens	_	KESIH		Name and Address	MA s of Facility	Y 05,2004	HAC	ERSTOWN M	neral Home
ä	Depa Impo any i		Manus	Ola	uley D	21	331 EAST	TERM				Sterm MD Approximate 21747
1	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each	ed the death. Do not line.			, such as ca	ardiac or respirator	y arrest,	, , , , , , , , , , , , , , , , , , ,	Approximate 2741 Interval Between Onset and Death 5 Months
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence	of):						
П		er	Sequentially list conditions, if any, leading to immediate		tinal Obs		ction					10 Days
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Coron	ary Arter	cy D	isease					Years
50,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a	as a consequence	of):						
68760,	icate l physics the b	edical	•	d								
.O. Box	it the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes ② No 9 □ Unknown		2 Fetel death at time of death		Ectopic pregnancy Other (specify)			nend.	23d. Date of de Month	livery Day Year
9	the see	by Ph	Part II. Other significant conditions co	ntributing to death	but not resulting in	the un	derlying cause give	n in Part I.	23e. D	id tobacc	o use contribute to	the cause of death?
ords	n requires been sign should be								1	□Yes	2 <sup>1</sup> No 3 □ Pr	robably 4 Unknown
Vital Records,	The law ate has b page 2 st	Completed							24a. W at pe 1 🗆 Ye	topsy enformed?	prior to death?	utopsy findings available completion of cause of 2 No
Ë	Physiclan: 1 this certifica	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ∐Inpa	tient 2□ER/Ou	*****	Other		Death (Check on		4.F30	
Division of	ding h. After fune	-	27. Manner of Death  12 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		ime of njury	28c. Injury Work	4 140121			jury occurred	cify)
Divis	i Dite	Certification:	3 Suicide 6 Could not be determined	building,	njury - At home, fa etc. (Specify)				City or	Town, Sta	ate)	ural Route Number,
	Hospitel	edical	29a. Certifier 1 XCertifying Phy (Check only one) 2 Medical Exami	rsician: To the bes iner: On the basis and manner:	of examination and	dor inv	occurred at the time estigation, in my opi	e, date and p inion, death	place, and due to t occurred at the tim	he cause ne, date a	(s) and manner as ind place, and due	stated, to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	1	12	71	A 29c. License	number		29d. [	Date signed (Mont	h, Dey, Year)
			»/ ) ) IN 19	N I I	MRIE	4	Y	D00220	043		5/3/20	04
, 1	1.3			ompleted cause of	death (flem 23a) (		'rint)			1		
	-54	to	31. Date filed (Month, Day, Year)	Wooster 32. Regis	11110 N	1edi	cal Campu	ıs Rd.	Hagersto	own,	MD 21742	,
	Sta Registr		MAY 0 4 20	04		1	2. 2. 3					

04-02		State of Maryland / Department of Health and Me			
Physici /Medio			2. Date of Death	Day 2004 Year	4 т <del>ре о реан</del> 2 0457 Р. м
Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Middletown  5. Social Security Number  6. Sex  217-21-3270  1	8. Date of Birth (Month, Day, ) FEB. 25,	4c. County of Death Frederic 9. Birth Cou 1988 Mary	k place (State or Foreign ntry)
death with the Maryland rms 23e or 28e-f show rmarke natified at	ctor	10a. State   10b. County   10c. City, Town or Location   Maryland   Frederick   Brunswick			10d. Inside City Limits 1 ✓ Yes 2 □ No
ath with th	Funeral Director	10e. Street and Number 10f. Zip Code 21716		Citizen of What Cou United St	ntry? ates
9 2 3	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Specific Specific Company)  14. Was Decedent of Hispanic Origin? (Specific Specific ify Yes or No- lican, etc.)	14. Race - Ameri Black, White		
within iene.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  Student	g	ib. Kind of Business/Ir	
land 2  Jid be filed the filed the filed of the filed the filed the filed the file event, the	To Be C	17. Father's Name (First, Middle, Last)  Richard Henry Scott Katherin	(First, Middle, Ma		Latudent
C = 44 F		19a. Informant's Name/Relationship (Type, Print)  Katherine Ann Scott / Mother  35 Wenner Dr./ Brunsw	Route Number, C	City or Town, State, Zip	
Baltimore, permit. Pages 1 ar Department of Hea mportent: If tiem my injury or othe once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  1  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Frederick Crematory 04/30/	ite 20	c. Location - City or To	own, State
Baltimor permit. Pages Department of t Importent: If ite any inlury or or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Sta  1621 Opossumtown Pik	uffer Fu	neral Home	21702
Physician /Medical Examiner		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shoot or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	respiratory arrest		Approximate Interval Between Onset and Death
OX 68760, certificate be executed refing physician and use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
Geath death of for u	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive	ory Day Year
HECONGS, P.O. he law requires that the e has been signed by th tge 2 should be detache	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
The ate h	e Completed	25. Was case referred to medical	24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
OT VITAL Physician: T rthis certificat ral director, ps	To B	examiner?  1 💆 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home		e 6 The ther (Specify	SCENE
Jing Jing Afte	Certification:	1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined elemined   28e. Place of Injury - At home, farm, street, factory, office   28e. Place of Injury	f. Localion (Stree Gity.or Town, S	Shot Set and Number or Rura	215
DIVISIC To the Hospitel or Attence within 24 hours after deatt To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and and anner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the caus at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier  Pollch 10  29c. License number  O.C.M.E.		Date signed (Month, Poril 28, 20	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street,  ARCIA (ON, CA POLLA MO)  31. Date filled (Month, Day, Year)  32. Registrar's Signature	Baltimo	ore, Maryla	and 21201
Stat Registra DHMH 17 Rev 1/20	ar	APR 3 0 2004 Server & Aponto			
		ORIGINAL			

			- State Amend Item #5 per	State of	M3/25/0	d / Depa <b>tas</b> <i>Cei</i>	artment of Ho tificate of L	ealth and N Death	lental Hygi ®	ene 2 () :	0 ls	16703
	Physici	an	Decedent's Name (First, Middle, Last)	0-					2. Date of Death Month		/ear	3. Time of Death
	/Medic	cal	Erika Vilhelmi				4b. City, Town, or	Location of Death	May 14	2004 4c. County of		7:10 a <sup>M</sup>
The state of the s	Examin	ier	4a. Fecility Name (If not institution, give st 19907 York Road		ber)		Parkton	Location of Death		Balt		e
. ,	Funeral Director	22	5. <b>\$391 9(suf) M</b> rpber 6. Sex		'. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 8, 1	907	9. Birthplac Country Esto	ce (State or Foreign onia
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				100	I. Inside City Limits
	Maryi	to	MD Baltimo	re	Pa	arkto	n					1 ☐ Yes 2 No
	or 28s	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wh	al Country	<b>y</b> ?
	23a uset b	ral	19907 York Rd.				21120			U.S		
21215-0036	s within 72 hours after death with the Maryland liene. I than "natural", or items 23s or 28s-1 show the Medical Exaciliar must be profitted at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	2 <b>(X)</b> No	'	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black,	White, etc	
2-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade			16a. Deced	lent's Usual Occupa kind of work done di OO NOT use retired)	tion uring most of work	ing 1	6b. Kind of Busi	ness/Indu	stry
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		oo not use retired) memaker			Own	Hom	۵
d 2	filed Hygi sther	Be Co	17. Father's Name (First, Middle, Last)			110.		18. Mother's Nam	e (First, Middle, M			
ılan	d be on the contract of the co	To B	Unknown					Unkno	wn			
Maryland	and and aum		19a. Informant's Name/Relationship (Typ				g Address (Street a					ode)
ď.	and least the per		Jueri Soots / 20a. Mathod of Disposition	Son	20b. P		907 York			MD 213 0c. Location - C		n State
nor	ages int of h t: If lite f or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	moval from S	tate Wis	ebur	sition (Name of natory or other place United	May	16,			,MD 21161
Baltimore,	permit. Pages 1 Depertment of H Important: If Ite any injury or ot ance.		21. Sign ure of Funeral Service in Inser	1000	Met	22	t Cemete Name and Address Second	s of Facility $J$ .	J.Harte	nsteir	n Moi	rtuary,I
20	*		23a. Part Enter the disease, or complic	ations that ca	used the death				<del></del>		A	pproximate
	Physician /Medical Examiner	-	sho k, or hear failure. List only one Immedia e Cause (Final disease ir condition resulting in death)  Sequentially list conditions.	Pa Due to (o		uence of):	TIC	CAN	ŒR		Ö	nterval Between
	icate be executed physician and the burial-transit	I Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		or as a consequ							
6876	ficate physics ts the	edical	d.									
.O. Box	The law requires that the death certificate be the same been signed by the attending physicis age 2 should be detached for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 10 0 9 ☐ Unknown	1 Live bir	ome of pregna th 2 Petal ant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date Month	_	
ds, P	uires that signed b ld be deta	ρ	Part II. Other significant conditions cont	nbuting to dea	ath but not resu	ulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contrib	ute to the	
i Records,		Completed			·				24a. Was an autopsy perform	ed? dea	ore autops or to comp ath?	y findings available letion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe	-	h (Check only one			
of	Phys this ral dii	1. To	1 ☐ Yes 2 No 27. Manner of Death	1 □ In	Injury	ER/Outpatien 28b. Time of	28c. Injury	at Nursing Ho	me 5 Cesider 28d. Describe hov	ce 6 Other		
lon	Attending r death. sctor: After by the funer	tlon	1 Natural 5 Pending investigation	(Month	, Day Year)	Injury	Work	? 'es 2 □ No				
Division		Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place o buildin	of Injury - At ho g, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,		or Rural R	loute Number,
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in I	Medical (	29a. Certifier (Check only one)		sis of examinat							
	To t with To t	×	29b. Signature and title of confier		w	-12	29c. License	846	<b>1</b>	d. Date signed (	Month, Da	)004
4	5		30 Name and address of person who con SERMON 1+.  31. Date filed (Month, Day, Year)	KAUTT	of death (Item	23a) (Type,	629 LON	6 CORNE	r Rund	White	Hmi	mD2116
*	Sta Regist		MAY 2 5 2	004	Ester of the second	M.	poets	<u> </u>				

,		State of Maryland / Department of Health and N  1- State Registrar  Certificate of Death	Mental Hygi	ene 2001	16704
		Decedent's Neme (First, Middle, Last)	2. Date of Death	1	3. Time of Death
Physici		B PRACT CALLER SAUDORIS	May 7,	Day Year	3:00A M
/Medic Examin		4h City Town or I posting of Dooth	-	4c. County of Death	
ZAGIIII	Ŭ.	Fort Washington Medical Center Fort Wash	_	P.G.	
Funeral Director		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Months Days Hours Min.	8. Date of Birth (Month, Day, June 9,	<sup>Yeer)</sup> 1930 W	place (Stete or Foreign intry) V
pu »		Usual Residence of Decedent  10a. Slate 10b. County 10c. City, Town or Location			10d. Inside City Limits
aryla •hov	5				12 Yes 2 No
the N 28a-f	ect	10e. Street and Number 10f. Zip Code	10	lg. Citizen of What Cou	intry?
with a or	ä	3424 Lumar Drive 20744		Jnited St	
death with the Maryland ms 23e or 28e-f show frame be notified at	Funeral Director	11. Marilal Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puert		14. Rece - Amer	
o differ o	필	Armed Forces? If Yes, specify Cuban, Mexican, Puerti	o Rican, etc.)	Black, White	
030 Surs a	þ	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 1 ☐ Yes 2 ☒ No Specify:		Specify: B1	ack
Ind 21215-0036  be filed within 72 hours after death with the Marylar latal Hygiene. And other then "netural", or flems 23e or 28e-1 show event, the Marylas Examiner mast be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work done	king 1	6b. Kind of Business/li	ndustry
2 E E E	n dr	Elementary/Secondary (0-12) College (1-4or 5+)  1 2 Homemaker		D == 1	_
d 21 filed w Hygier ther th			na (Cina Adiotalia Ad	Privat	e
be fill the be out	Be	Cansiald Canton	ne (First, Middle, M Craft	alden Sumame)	
J Mer	ဥ			City of Town State 7	in Code)
re, Maryland s 1 and 2 should be file t Health and Mental Hy ltem 27 le marked oth other traumatic event		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru 3424 Lumar Di 3424 Lumar Di Fort Washing	rai Houle Number,	20744	p Code)
C = '4 F	13	20a Method of Disposition 20b. Place of Disposition (Name of		0c. Location - City or T	
Limor Pages Iment of Iant: If It		1 Burial 2 Cremation 3 Removal from State Roce lawn Mem Gardens	0		ton, WV
		21. Signiture of Funeral Service Licensee 22. Name and Address of Facility			
Balt permit. Departr Importa		Minuse Edwards 3910 Silver Hill			
		23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate
180		Immediate Cause (Final		LALL	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  Due to (or is a consequence of):	TOUS	ww.	100.13
Examiner		Attail Silvalla	tim		dows
111111	ner	Sequentially list conditions			()
outed ansit	Examir	Cause (Disease or injury that initiated events			villes
766, be executed sicien and burial-transit	EX	resulting in death) Last Due to (or as a consequence (1):			
7 0	licai				
<b>⊕</b> 50 €	Physiclan/Med	IF FEMALE:			-
Box auth cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?		23d. Date of deliver Month	rery Day Year
. 0 00	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	<del></del>		
P.O. that the ded by the detached			23e. Did Ioba	acco use contribute to	the cause of death?
	d by		1 🗆 Yes	s 2 No 3 Pro	bably 4 ZUnknown
Vital Records alcien: The law requires certificate has been sign rector, page 2 should be	ompleted		24a. Was an	24h Were aut	opsy findings available
I Rec	mp		autopsy	prior to co	ompletion of cause of
Vital F	e Co			□ No 1 △ Yes	2 No
	o Be	examiner?	th (Check only one	nce 6 Other (Speci	4.1
	-		28d. Describe hov		lly)
Vision ( Attending I death. ector: After by the funer	tio	1 <del>☑Na</del> tural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Acciden! investigation M 1 ☐ Yes 2 ☐ No			
Division of Attending after death. Director: After	ifica	3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rui	al Route Number,
Disafte safte	Certification:	building, stc. (appeary)	ony or rown,	State	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place	, and due to the car rred at the time, da	use(s) and manner as te and place, and due	slated. to the cause(s)
To the I within 2 To the I complet	Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Month)	, Day, Year)
		M. M. L _ m 046046		5-7-	4004
5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	#1 101-1	, < , , ,	AD DATIM
	ate	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  29c. License number  046046  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Amir Mira - Alikham II7II Livingsfon Rd.  31. Date filed (Month, Day, Year)  32. Registrar's Signature	TT. Wast	ungten,	NO 20144
Regist	rar	MAY 25 2004 States & Species"			

			1- State mend Item #15	State of Ma	aryland / De 832 <b>,</b> 6/21 <i>d</i>	partment of H Oftificate of I	lealth and Death		giene Reg. No.200	4 16705
			1. Decedent's Name (First, Middle, Las.					2. Date of Da Month	ath	3. Time of Death
	Physici /Medic		Charles R	ichard	Sween	<b>Э</b> У		05	11 200	
	Examin		4a. Facility Name (If not institution, give	1 . 1	: Hal	4b. City, Town, or			4c. County of	
			Sacred Heat 5. Social Security Number 6. Se		e (In yrs. last birthd		er an			
	Funeral Director			ZM 2DE	Yrs	Months Days	Hours Min		, 1919	Birthplace (State or Foreign Country)
	D.		Usual Residence of Decedent			Lagrica	-			10d Incide Circlinia
	shov	j.	MD Allegan	V	10c. City, Town o	nberland				10d. Inside City Limits 1√2 Yes 2 □ No
	the N	Director	10e. Street and Number	,		10f. Zip Code			10g. Citizen of Wha	
	3e or	i Di	1 Baltimore Street				21502		USA	\
	death	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?	Ever in U.S.	Was Decedent of H.     If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No	14. Race -	American Indian, White, etc.
36	within 72 hours effer death with the Maryland jiene. r then "neturel", or Items 23e or 28e-f show the Medical Examination of the collided at	by Fu	1 Never Married 2 Married	1 □ Yes 2 ▼ N If Yes, Give	40	1 ☐ Yes 2 No	Specify:	10 1110411, 0101,	Specify: V	
21215-0036	hours turel'		3X Widowed 4 □ Divorced  15. Decedent's Edi	Year or Dates:	16a De	ecedent's Usual Occupa	ation		16b. Kind of Busin	
15	in 72 n "ne	piet	(Specify only highest grad	de completed) College (1-4or 5	(G	ive kind of work done o e. DO NDT use retired	during most of wo	orking		
212		Completed	12	4	flight	controller			·	ican Airway
Maryland	be filed valued by the filed value of other feether fe	Be	17. Father's Name (First, Middle, Last)	Curaanau					, Maiden Sumame)	,
3	should be nd Mental marked o	ဥ	Michael Gabriel  19a. Informant's Name/Relationship (7		19h M	ailing Address (Street a			Sweeney	ite. Zin Codel
			Kathryn Folk	daug		0 National F		LaVa		MD 21502
ore,	as 1 and 2 of Heelth a litem 27 I		20a. Method of Disposition  1  Burial 2  Cremation 3	Domeyal from State		sposition (Name of crematory or other place	(9)	Date	20c. Location - Cit	y or Town, State
ij	Pages ment of I ent: If its ury or of		'4 □ Donation 5 □ Other (Specify		Scarpelli F	Funeral Home		5/14/2004	Cresapto	wn MD
Baltimore,	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service Licens	· \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	000:	22. Name and Address Scarpell			rland, MD 21	502
			23a. Part1. Enter the disease, or composhock, or heart failure. List and	lications that caused	the death. Do not					Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition	Bo	adver	HLOA				Onset and Death  O Manuel
	/Medical Examiner		resulting in death)	Due to (or as	a consequance of):		. 0			
	E Adminion	e	Sequentially list conditions.	b. Diseito for as	a ununderenda nu	3 yourse	y ws	200		chkrous
	uted i insit	mine	Tary, leading to firm edials cause. Enter Underlying Cause (Disease or injury			,				
) (	execu en and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence of):			-		
8760,	cate be executed physicien and the burial-transit	dicai		d						
9		/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy					
Вох	death certific e attending p id for use as	Physician/Me	in the past 12 months?		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of Month	1 delivery Day Year
o.		nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	tano or dozan	o 🗆 o (1) o (1) o (1) o (1)				
S, D	taw requires that the as been signed by th 2 should be detache	by Pl	Part II. Other significant conditions co	entributing to death be	ut not resulting in th	e underlying cause give	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?
ords	w require been sig should b		HYPOTENSO	2				1 🗆 Y	Yes 2 No 3	□ Probably 4 □Unknown
of Vital Record	e taw ru has be je 2 sh	ompieted	milo Demen	7A				24a. Was autop	osy prior	e autopsy findings available r to completion of cause of
<u> </u>	ate pag	Con						perto.	rmed? deat 2 ☑ No 1 □	th? Yes 2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	200	ath (Check only o		
of	Phys	. To	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Inju	nt 2□ER/Outpa ry 28b. Tim	e of 28c. Injury	4 □ Nursing F		dence 6 Other (	Specify)
O	Attending F r death. ector: After by the funer	ition	1 ☐ Matural 5 ☐ Pending investigation	(Month, Day	γ Year) Injui	y Work	(? Yes 2 □ No			
Division	or Attendiater death.  Director: A	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju		street, factory, office		28f. Location (S City or Tox	Street and Number o	or Rural Route Number,
ō	rs after el Dire	O		Danding, on						
	To the Hospitel or Atten within 24 hours after deatl To the Funerel Director: completely filled in by the	edical			examination and/o	eath occurred at the time r investigation, in my op				
Q	To the within 2 To the complet	Med	29b. Signature and title of pertifier	. \(()	V	29c. License	number		29d. Date signed (M	Month, Day, Year)
)	1		► NOS	sen (h)		DE	31875		MAY 1	1,2004
	1		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (Type 2 Setor	De. Print)	Cumbe	erland	Maryla	nd 21502
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar Signature	K fords	p1 ;		)	

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Alice Snyder 12:10 PM 05 4-2004 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death SACRED HOSPITAL HEART CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 229-26-5216 1 M 2 X 94 Mar 24, 1910 WV Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Mineral Ridgeley 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Central Avenue 26753 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Ø Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Ellis Mcle Sarah (Lake) Mcie 19a\_Informant's Name/Relationship (Type, Print) Ronald Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 201 Forest Drive Cumberland MD 21502 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Restlawn Memorial Gardens 5/18/2004 \* 4 □ Donation 5 □ Other (Specify) LaVale MD 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Euneral Service Licensee Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberla 23a. Part1. Enter the disease, or nome lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE FAILURE 2 DAYS HEART Due to (or as a consequence of): LOWER LUBE PROUMONIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): UROSEPSIS Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy

**Physician** /Medical Examiner

attending physician

signed by the a

has

this certificate

i Director: After the in by the funeral

within 24 hours a

þ

Completed

Be

T<sub>o</sub>

Certification:

cai

Medi

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

Director

by Funeral

Be Completed

2

ir than "natural", or items 23e or 28a-f sho

death with the Maryland

72 hours after

al Hygiene.

2 should be fi and Mental H is markad of

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumetic every

Baltimore, Maryland 21215-0036

Examiner

Physician/Medical 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 Hinknown

4☐Pregnant at time of death 9 Unknown

5 Other (specify)

Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 Probably 4 Unknown

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

	25. Was case referre examiner?  1 \( \text{Yes} \) 2 \( \text{TM} \)	/
ľ	27. Manner of Death	5 Pending

2 Accident 3 🗌 Suicide

investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

determined

Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one) 29b. Signature and title of certifig

4 Thomicide

MO

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924

VELANDIA 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

23e. Did tobacco use contribute to the cause of death?

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DO 8377

14-04

CUMBERLAND md.

Seton DRIVE

**ORIGINAL** 

•	To the Hospital or Attending Physical Minior 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.	Medical	29b. Signature and title of certifier  30. Name and iddress of person who con	ician: To the best of my knowledge, er. On the basis of examination and and manner stated.	29c. Licen D4416	se number	ned at the time, da	ed. Date signed (Monay 13, 200	nth, Day, Year)
Divisio	ital or Attent rs after death al Director: led in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)			28f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
Jo uc		tlon: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Tir	ne of 28c. Injury	4 🔲 (Auraing Fi	ome 5 🕰 Reside 28d. Describe ho	nce 6 Other (Spewinjury occurred	ecify)
⋚		o Be	examiner?	ospital: 1 Clinnatient 2 CER/Outn	atient 3000 Ot				ecifu)
Division of Vital Records,	The la ate has page 2	• Completed	25. Was case referred to medical			26 Place of Dea	24a. Was ar autopsy perform 1 Yes 2	y prior to death? No 1 ☐ Ye	autopsy findings available completion of cause of is 2 No
ords, P.	w requires that the sbeen signed by the should be detache	þ	Part II. Other significant conditions con Cancer Cachexia	•	he underlying cause gi	ven in Part I.			to the cause of death?  Probably 4 Munknown
P.O. Box 68	death certifica e attending ph ed for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnanc 5 □ Other (specify) _	ey .		23d. Date of de Month	elivery Day Year
760,097	Physician /Medical Examiner	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Myocardial Isch Due to (or as a consequence of Metastatic Aden Due to (or as a consequence of Due to (or as a consequence of	ocarcinoma				Hours Months
<b>a</b>	80 5 8 9		23a. Part1. Enter the disease, or complice shock, obeart failure. List only on	M00999  ations that caused the death. Do not be cause on each line.				ederick, l	MD 21701  Approximate Interval Between Onset and Death
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	Smithsb	urg Cremat	ory 5/13			g, Maryland Funeral Home
e, l	is 1 and 2 should of Health and Men teem 27 is marke other traumatic		Steven Z. Runnells 20a. Method of Disposition	The state of the s	6 Deer Spr disposition (Name of crematory or other pla		7000	OWN , MD 2 20c. Location - City o	21769 or Town, State
Mary	2 should and Men is marke	1	19a. Informant's Name/Relationship (Typ		Mailing Address (Stree				
lan	should be nd Mental marked c	ToB	unavailable			Marilyn	Shavende	r	
d 2	filed Hygin other	Be Co	17. Father's Name (First, Middle, Last)	Je1	. <u>L</u>	18. Mother's Nan	ne (First, Middle, A		
1215-0	within 72 ho ane. then "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) 16a. C () College (1-4or 5+) Se1	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of wor ad)	rking	16b. Kind of Busines Homemaker	s/Industry
920	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. Indicate then "natural; or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funerai		2. Was Decedent Ever in U.S. Armed Forces? 1Yes _ 2\overline{M} No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub  1 ☐ Yes 2 ☒ No			14. Race - Arr Black, Wh	
	3a or 2	i Dire	10e. Street and Number 4316 Deer Spring R	oad	10f. Zip Code 21769			0g. Citizen of What C SA	country?
	se Maryland	Director	10a. State 10b. County  Maryland Frederick	10c. City, Town	wn				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	Director		223-27-4041 Usuel Residence of Decedent	M 2X F 37 YI	s. Months Days	Tiours Iviiri.	Nov. 20	, 1966 Vii	rginia
	Funeral		4316 Deer Spring R 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Middlet  day) If Under 1 Year  Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Frederic 9. Bi	K_ irthplace (State or Foreign Country)
	Examin		4a. Fecility Name (If not institution, give s			or Location of Death	1	4c. County of De	
	Physici /Medio		Annette Byrd Shave	nder			May 12,	2004	6:50 P M
			Registrar     Decedent's Name (First, Middle, Last)		ortinicate or	Doui!!	2. Date of Deat		3. Time of Death
			1 - State Registrar	State of Maryland / Do	epartment of I Certificate of			ene 19. No. 200	1. 16707

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 68 Month 2004/17/2 **Physician** Donald Schattenberg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center NIA Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 79 February Maryland 578-28-4889 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 Yes 2XXNo Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21702 7203 Drought Spring Drive Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or ite, any injury or other traumatic event, the Medical Exempter 1 Never Married 2 Married 1 XX Xes 2 □ No If Yes, Give Year or Dates: WW2 Baltimore, Maryland 21215-0036 1 Yes 2 X Xo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government/ Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Ft. Detrick 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Marguerite Martin Elmer Schattenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7203 Drought Spring Drive/Frederick, Maryland 21702 Evelyn\_Schattenberg/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Jurial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) May 12, 2004 | Frederick, Maryland Mt. Olivet Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. The street of th destre 1621 Opossumtown Pike/Frederick, Maryland 21702 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 days **Physician** neumonia /Medical Due to (or as a consequence of **Examiner** ongestive Heart Failure days Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physicien and r use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 sl autopsy performed' 1 ☐ Yes 2 🔀 No 1 TYes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler ozano MiD MAY 08, 2004 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MARYLAND 21201 22. S. Creene Jorge LOZANO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 1 2004 Registrar

			1 - For Stata Registrar	State of	Maryland / De	partment ertificate			Mental H	ygien Reg. N	-	n I.	16700
	Physic /Medi		Decedent's Name (First, Middle, La:     HAZEL EILEEN	soudi	ER				2. Date of E Month May		2004	Year	3. Time of Death 12:58 P M
	Examir		4a. Facility Name (If not institution, give 800 Motter Avenue	#216		Frede	rick				c. County of	rick	
	Funeral Director		5. Social Security Number 577-32-6629 1  Usual Residence of Decedent	ex □M 2☐XF	7. Age (In yrs. last birthdi 77 Yrs	Months	Days	If Under 24 H Hours Mi		Sirth Day, Yea	( <sup>2</sup> 927	9. Birthp Coun Mar	lace (State or Foreign try) 'Yland
	ne Maryland 8e-f show	Director	10a. State 10b. County Maryland Frederic	:k	10c. City, Town or Frederi	ck							0d. Inside City Limits 1 X Yes 2 □ No
	ath with the 23a or 2	ral Dire	10e. Street and Number 800 Motter Avenue				701			ı	United Of W	d Sta	ates
900	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then and Mental Hygiene. Item 27 is marked other than "neturel; or liems 23s or 28e-1 show other treumstic event, the Medical Exercipation at the multiple at	d by Funeral	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Dece Armed For 1 □Yes If Yes, Give Year or Da	ces? 2 X No	3. Was Deceder If Yes, specify 1 Yes 2		panic Origin? Mexican, Pue Specify:	(Specify Yes or Norto Rican, etc.)	lo-	14. Race Black Specify:	White, e	etc.
Baltimore, Maryland 21215-0036	d within 72 h giene. or than "netu The Medica	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		4or 5+) (G	cedent's Usual ( ive kind of work b. DO NOT use urses A	done du retired)	on ring most of w	orking		Kind of Bus		lustry
yland	2 should be filed within and Mental Hygiene. is marked other than eumatic event, the Mental than the most of the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and the mental transcript and tra	To Be C	17. Father's Name (First, Middle, Last) Willard Lansdale	Souder				Cora	ame <i>(First, Middl</i> El <b>i</b> zabet	h Bo	oyer		
e, Mar	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship ( Ellen Green  20a. Method of Disposition	Type, Print)		Windy	Kno1		Mt. Air	y, l	MD 21	1771	
timor	t. Page ntment o rtent: if		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif)  21. Signature — Funeral Service Licer	<i>'</i> )	Metropol	rematory or othe itan Cr	er place) emat	orium	5/7/2004	ı A	Location - C	ndria	
Ba	Deparition of the control of the con		23a. Part 1. Enter the disease, or com	Usy		26401 R	idge	Road.	h, P.A. Damascu	is. N	eral H Maryla	Home and	20872 Approximate
	cate be executed XXI Medicial and many ith price that the britantial transit in the britantial t	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Under viru. Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c		HEART	D	) JEA	52_				Interval Between Onset and Death
O. Box 68	the death certific by the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live bir	nt at time of death	3 □Ectopic pregi 5 □ Other (s <i>peci</i>					23d. Date Mont		y Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of HYPERTERS LC		ath but not resulting in the			in Part I.	11		_		cause of death?
of Vital Records,		Completed							24a. Was auto perf 1 Ves	s an opsy ormed?	pri	or to com ath?	sy findings available pletion of cause of
Division of Vita	or Attending Physicien: ] after death. Director: After this certifica in by the funeral director, p	ertification: To Be	25. Was case referred to medical examiner?  1	28a. Date of (Month)	patient 2 ER/Outpat Injury Day Year)  of Injury - At home, farm, g, etc. (Specify)	of 28c.	Other: Injury at Work? 1  Yes	4 ☐ Nursing	Home Res 28d. Describe 28f. Location City or To	idence how inju	ury occurred	1	Route Number,
5	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edical Cer	29a. Certifier 1	ysician: To the t	pest of my knowledge, de sis of examination and/or	ath occurred at t	he time,	date and plac	e, and due to the	cause(s	and man	ner as sta	ted.
	To the P within 24 To the C complete	Medi	29b. Signature and title of certifier	and manne	er stated.	29c. L	icense n				ate signed (		
2	ر		30. Name and address of person who of A . DONNECSON MD	completed cause		4 '	B	ح. F	-REDER!	ck	mo	21	1702
	Sta Registr		31. Date filed (Month, Day Your)	0 2004 ▶	gistrar's Signature	4		1 22					

as the burial-transit

**Physician** 

/Medical

**Examiner** 

Director

by Funeral

Completed

Be

MD

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28s-f show any injury or other treumatic event, the Medical Examiner nust be notified at once.

Baltimore, Maryland 21215-0036

	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailing Add	ress (Street and Nu	mber or Rural I	Route Number, C	ity or Town, State,	Zip Code)
	MELVIN SWORD	/ HUSBAND	)	302 WII	LS CREEK	<b>AVENUE</b>	, CUMBER	RLAND, MD	21502
	20a. Method of Disposition 1	Removal from State	CE	ace of Disposition emetery, crematory PETER & I	or other place)	Dat		c. Location - City o	
	* 4 □ Donation 5 □ Other (Specify,		20.			1			D, IID
	21. Signature of Funeral Service Licens	Unchu	NO	202	HÜRCH FÜN GREENE S	TREET,	CUMBERLA	ND, MD	21502
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	ne death	. Do not enter the	mode of dying, such	n as cardiac or	respiratory arrest		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. MyoCo	and	ial In	forceles				Onset and Death Wineles
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a c	consequ	ience of):					
al Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequ	ence of):					
200	•	d							
ysicianymenical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal	death 3 Ectop	ic pregnancy r (specify)			23d. Date of de Month	elivery Day Year
pieted by Pri	Part II. Other significant conditions on Hyperferrior,	4.5			ng cause given in P	art I.			to the cause of death?  Probably 4 Unknown
Complete	1						24a. Was an autopsy performed	prior to	
e	25. Was case referred to medical				26. P	lace of Death (	Check only one)		
0	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient	2/5	ER/Outpatient 3	DOA Other: 4[	Nursing Home	5 Residence	e 6 Other (Sp	ecify)
ation:	27. Manner of Peath  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	Year)	28b. Time of Injury M	28c. Injury at Work?	28	d. Describe how		
Sering	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At ho (Specify	me, farm, street, fa	ctory, office	28	If. Location (Stree City or Town, S		Rural Route Number,
edical Certification		vsician: To the best of iner: On the basis of e and manner state	xaminal						
Ā	29b. Signature and title of certifier				29c. License numl	ber	29d.	Date signed (Mor	oth, Day, Year)
	- '	www MI)	-		D4634	16	5	0-10-0	)4
	30. Name and address of person who o	completed cause of dea	th (Item	. 1	0	2-1-201	m Lon	1 2160	7
	DR. MUMA SHA!	32/ Registrar	s Signa	ent Avei	nue, cu	mberl	HIIQ III	U 0000	<u> </u>
e	31. Date filed (Mach, Day, Year)	S. riegistral	s Gigila	19 M	no Val				

Registrar DHMH 17 Rev 1/2001

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		State of Maryland / Department	artment of Health and Me		ne2004	16711
		Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physicia		OREN NEAL TIERNEY	<sub>M</sub>	Month IAY 12	Day Year 2004	8:04 A M
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
		MEMORIAL HOSPITAL	CUMBERLAND		ALLEGAN	
Funeral Director		5. Social Security Number 6. Sec. 7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.   M	B. Date of Birth (Month, Day, Y  arch 15	9. Birt. Co	hplace (State or Foreign untry)
pur A	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
Aarylan I show	ō	WV HAMPSHIRE SPRING	CITT			1 ☐ Yes 2 ☐ No
28a-	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
3a or		P. O. BOX 498	26763	U.	S.A.	
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Apped Forcas?	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri		14. Race - Ame Black, White	
after at the control of the control	F	1 □ Never Married 2 Narried 1 No 2 □ No	1 ☐ Yes 2 ☐ No Specify:			ite
ural',	d by	3 ☐ Widowed 4 ☐ Divorced Sear or Dates: 1951	Identia Liqual Convention	16	b. Kind of Business/	
n 72 I	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	7	D. Killy of Busilless	moustry
withi than	dwo	Elementary/Secondary (0-12)   College (1-40r.5+)	aintenance		School	
be filed within 72 hours after death with the Maryland hall tyglene.  Ital Hyglene death with the Maryland of other than "natural", or frems 23a or 28a-f show event, the Madrel Extrument count be notified at	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Ma	iden Sumame)	
yidalid Z I Z buld be filed with Mental Hygiene arked other tha atic event, man	To B	JOHN WOLFORD TIERNEY	ELVA TA	CY		
Lary latter A LA. 2 should be fitled within and Mental Hygiene. Is marked other than aumatic event, than aumatic event, than			ing Address (Street and Number or Rural		-	Zip Code)
and and and and and and and and and and		The Control of the Co	Box 498, SPRINGFI			Taura Chata
Dallittinore, Marylati permit. Pages 1 and 2 should by Department of fealth and Menta Important: If them 27 is marked enty injury or other traumatic en		1   Huriai 2 Micromation 3   Hemoval from State	matory or other place)		c. Location - City or	
Distriction  Sermit. Pages Department of Important: If it any injury or o					CRESAPTOW	N, MD
permi Departiment in			2. Name and Address of Facility SHAF 230 E. MAIN ST., RO			
	-	23a, Part1. Enter the discusse, or complications that caused the courth. Do not en				Approximate Interval Between
<b>P</b> i-		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final				Onset and Death
Physician /Medical		disease or condition resulting in death)  EMPHYSEMA  Due to (or as a consequence of):				30 YEARS
Examiner		b b				
₽ ≅	ner	Sequentially list conditions, if any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that inflated events  c.				
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
rou, te be executed ysician and te buriat-transit	cal E					
ob/		d				
OX 08 h certifical ending phy	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of del	ivery
death death ele atter	Iclan	in the past 12 months?  4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
that the ed by the detache	hys	9 Unknown				
S 5 6	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?
w requires to be a sign should be	ted	PERIPHERAL VASCULAR DISEASE		A res	2 No 3 Pr	obably 4 Unknown
4.5 - 0.70	Completed			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
The law cate has I	Co			1  Yes 25	No 1 □ Yes	2 No
OT VITAL Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death		6 TOther (6	alfa)
On Of VITa ding Physician: h. After this certific funeral director,	1: To	1 ☐ Yes 2 ☑ No	of 28c. Injury at 28	Bd. Describe how	ce 6 Other (Spe injury occurred	Cny)
VISION Attending or death. ector: After by the fune	tor	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
DIVISION  or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 25	8f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
Spital or A cours after neral Direction by filled in by	Cer	3,				
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.				
To th withir To th comp	Me	29b. Signature and title of certifier H. Chilani.	29c. License number	290	I. Date signed (Mont	h. Day, Year)
		11.000	D58853	MA	AY 12, 200	)4
4		30. Name and address of person who completed cause of death (Item 23a) (Type				
,		CHOTANI, HABIB, M.D., 131 PENNSYLVAN  31. Date tiled (Month, Day, Year)  32. Registrar's Signature	IA AVENUE, CUMBERLA	ND, MD 2	21502	
St Regist	ate rar	MAY 2 5 2004 Description of the state of the	souls:			

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			. For	State of Marylan						10710
	,		1 - State Registrar		Cei	rtificate of	Death	Re	g. No. 2004	10/12
П	Physici		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Marmaduke E.	• Warner				May 10		13:05 M
	Examir		4a. Fecility Name (If not institution, give s	,		4b. City, Town,	or Location of Deat	1	4c. County of Deeth	1
	7		Prince Georges				Cheverly		P.G.	
	Funeral		5. Social Security Number 6. Sex	TM 2FF		If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Birth Cou	nplace (State or Foreign untry)
* . F\$	Director		095-32-6091 1 Number		90 Yrs.			Nov. 24,	, 1913 F	Panama
	yland yland	!	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mar	ţ	Md. P.G.	J	Bowie					1XYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	th wi	al	15006 John C	ourt		207	21		United S	tates
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. V	Was Decedent of I	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		XYes 2□ No			C	
Ö	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel", or items 23a or 28a-f ahow imatic event, the Medical Exercition was been neithed.	d b	3 Widowed 4 Divorced	Year or Dates:	100 B		га	namania		Black
5	n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	lent's Usual Occup kind of work done OO NOT use retire	pation during most of wor ad)	king	6b. Kind of Business/li	ndustry
77	with ene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		pping			Private	•
Maryland 21215-0036	Hygi other	Be C	17. Father's Name (First, Middle, Last)			T T 3		ne (First, Middle, Ma		
<u>a</u>	Mental Mental arked o	To B	Barris Ford War	ner			Martha	a Griffi	th	
ary	should and Men Is marke	1 15	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number. (	City or Town, State, Zi	p Code)
_	ガキアギ		Brenda Yard/dau	ghter	Bow	e, John	igk729u	rt		
Baltimore,	permit. Pages 1 and Department of Healt Important: if item 2 eny injury or other 9005.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	20b. P	lace of Disposemetery, crem	sition (Name of natory or other pla	ice)	Date 20	c. Location · City or T	own, Stete
Ĕ	Pages ment of I ant: If its ury or o		'4 □Donation 5 □ Other (Specify)		surrec	ction C	em. 5/	14/04	Clinton,	Md.
ä	Departr Departr Importa eny inji		21. Signature of Funeral Service License	* / 2 . /	/			_	Edwards	
	20E 3 9		yence E	awards	/ 39	10 Sil	ver Hill	Rd., S	uitland,	MD.20746
	Physician /Medical Examiner	ner	23a. P641. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cisease or injury that initiated events.	Due to (or as a consequence of the consequence of t	uepce of):	E Pro		0	enone	Approximate Interval Between Onset and Death
68760,	ntificate be executed ng physician and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last c.	Due to (or as a consequ	uence of):				п	
C. Box	at the death certificate by the attending phy lached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	ac. If yes, outcome of pregnal  1 □ Live birth 2 □ Fetal  4 □ Pregnant at time of de  9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	у		23d. Date of deliver Month	ery Day Year
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r	Ф <del>г</del> б	Ho						autopsy performe 1 ☐ Yes 2X	prior to co death?	
	iicien: Th certificate rector, pag	Se C	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2X	No 1 □ Yes	2□ No
>	Physicien: r this certific ral director,	To B	examiner?	ospital: Inpatient 2 1	ER/Outpatient	3□ DOA Oth		The second secon	ce 6 Other (Specif	iv)
ion of	anding Pt ath. rr: After th		27. Manner of Death  1 Natural 5 Pending investigation	28a. Ate of Injury Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1		28d. Describe how		,
DIVISION	To the Haspital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	(3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura State)	I Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifying Physi (Check only one)	cien: To the best of my know er: On the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as si and place, and due to	lated. the cause(s)
	To To E	Σ	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Month,	Dáy, Year)
•	,		1/ fre	1	10	1	303,	18 3	5/10/0	V
	5		30. N me and address of person who com			•				
	1		Dr. James Cater 31. Date filed (Month, Day, Year)	ivis, 3001	Hospi	tal Dr.	, Cheve	rly, Md.	20785	
	Sta Registra			32. Registrar's Signation 5	ure	April .	- "			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** [FIVE JOHNWESLEY WILLIAMS MAY 09 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Baltimore Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Nov.2, 1939 Director 463-64-7377 Texas 64 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r then "naturel", or items 23a or 28e-f ehow the Medical Examiner must be rediffed at 1 Yes 2 □ No Director Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 62 Foxrock Drive 21773 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other them eny injury or other treumetic never Elementary/Secondary (0-12) College (1-4or 5+) 12 Scientific Research Senior Scientist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rosalie Williams Ingram Lewis Frazier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 Foxrock Drive, Myersville, Maryland 21773 Allandos Williams/wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt.Zion U.Methodist May 12, 04 Myersville, Maryland 1.4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Full eral Service License 22. Name and Address of Facility 504 Main Street Myersville, MD 21773 Ricketts Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION DAYS /Medical Due to (or as a consequence of): **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on Examiner requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year for Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by to should be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No VENTRICULAR ARRYTHMIA 24a. Was an autopsy performe 1 Yes 2 No of or Attending Physicien: after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours af To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Withicum D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 OSLER DRIVE TOWSON MARYLAND 21204 RICHARD LINTHICUM M. D. 7601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 1 2 2004

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 6:50AM **Physician** la /Medical Town, or Location of Death County of Death 4a. Facility Name (If nat institution, give street and number) Examiner Baltimore Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 5. Social Security Number 7. Age (In yrs. last bjrthday) **Funeral** 6925 1 1 M 2 □ F 26 Yrs Director Usual Residence of Decedent 10d. Inside City Limits the Maryland City, Town or Location 10a State 10b. County 10c perm t. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23e or 28a-f show any it urry or other traumatic avent, the Medical Examinat trausite in Lifting at once. Baltimore 1 PYes 2 No by Funeral Directo 10g. Citizen of What Country? 10e. Street and Nymber 10f. Zip Code 21239 1320 wenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Tes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electrician 18. Mother's Name (First, Middle, Maiden Sumame) (Eirst, Middle, Last, To Be 19b. Mailing Address (Street and Number or Balto 212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundrel Service Lice 22. Name and Ap roximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease r condition resulting in death) Physician /Medical Examiner مالي organization in the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. funeral director, page 2 should be 4 Unknown 3 Probably 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 XNo 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the within 24 hours after deat To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DI 898

State Registrar

DHMH 17 Rev 1/2001

MAY 2 6 2004

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30. Name and address of per

31. Date filed (Month, Day, Year)

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

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MD 21239

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death

1 - For State Registrar

Division of Vital Records, P.O. Box 68760,

	/Medic		BENJAMIA DURWELL	MAY	19 2004 5:15am
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. County of Death
			MAHOR CARE TOWSOH Towson		BALLINE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F Months Days Hours M  Usual Residence of Decedent	Irs. 8. Date of Birth (Month, Day, You	O Birthplace (Ctota as Foreign
	and *		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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	Ne N	ect/	1 17 9 1812		
	diff t	Ö		10g	. Citizen of What Country?
	ath v	ral	1802 Estaro Place 21317		USB
	tems	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify: a /
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Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	HATRIAN	MATTI TONES MANG
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	and tran-	Examin	cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
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	To the Hospitel or Atti within 24 hours after de To the Funerel Directi completely filled in by t	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Dey, Year)
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	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Tangen	un 2/286
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Registrar

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Physician Medical Examiner    Physician Medical Examiner   23a. Phil: Enter its disease, or semplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	) Ore	ges 1 t of H if Ite		1 XBunal 2 ☐ Cremation 3 ☐ Removal from State   Cemetery, crematory or other place)	
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FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Suicide   1   No performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 2	ó	an an an arial-tr	Exa		
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5/20/2004		Hospil A hour Funer letely fills	dical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
5/20/2004		To the	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 2 6 2004  April 12 Apri		0.1		Lain N. Allen My Do7421 5/20/2004	
State Registrar MAY 2 6 2004 April 10 A	1	At,		30. Name and address of person who completed cause of death (tem 23a) (Type, Print)  LOUS W. Miller HD. 1838 Everue Tree Rb #300 RATOM 21208	
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S			For State	State of Ma		artment of Health		lygiene 004	16717
	Physicia	an	1. Decedent's Name (First, Middle, I	Brown			2. Date of Month	Death Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or Location		23, 2004 4c. County of Dea	1145 a M th
	Funeral		526 S. Chapelgat  5. Social Security Number 6.	Sex 7. Age	e (In yrs. last birthday)		1000111-0	Birth 9. Bir	thplace (State or Foreign
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36	72 hours after death with the Maryland neturel; or tems 23e or 28e-f show iteal Examinar must be motified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	<b>d</b> o '	1 ☐ Yes 2 No Spec		Specify: Q	IACK
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2121	ad within /giene. er then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	(+)	Disability			
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Mary	d 2 shouth and N 7 is man		19a. Informant's Name/Relation hip	(Type, Print)	19b. Mailir	ng Address (Street and Nu	mber or Rujal Route Nui	mber, City or Town, State,	Zip Code)
-	les 1 an of Heal if item 2 or other		20a. Method of Disposition	☐Removal from State		sition (Name of matory or other place)	Date	20c. Location - City or	Town, State
altimore	tmer rtent right		4 □Donation 5 □ Other (Specal Signature of Funeral Service Lice	cify)	Lakevieu	Cemeteny  Name and Address Fa	5-28-04	Green 1	g, MD
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Box	death certific e attending p ed for use as (	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1⊟Live birth 4⊟Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
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	es ign be	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause given in Pa		id tobacco use contribute to ☐ Yes 2 No 3 ☐ P	robably 4 Unknown
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Division	Attending I r death. sctor: After by the funer	Certification;	Natural 5 Pending investigat 3 Suicide 6 Could not	ion		M 1 Tes 2		(Charles of Allerton on B	Davida Alvaria
Divi	s after d st Direct at Direct	Certiffi	4 Homicide determine		ury - At home, farm, sti c. (Specify)	eet, factory, office	City or	n (Street and Number or R Town, State)	urai Houte Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeret Director: completely filled in by the	edical (	29a Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examination and/or in	h occurred at the time, date vestigation, in my opinion,	and place, and due to t death occurred at the tin	he cause(s) and manner a ne, date and place, and du	s stated. e to the cause(s)
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	9		30 Name and address of person wh	no completed cause of d	leath (Item 23a) (Type,	Deint	Street Pal	timore, Mary	-
	Sta	te	31. Date filed (Month, Dav. Year)	Lock 1	rar's Signature		outer, bal	chiore, Mary	TOTAL CICUI
il.	Regist		31. Date filed (Month, Day, Year) MAY 2 6 2004	Benjara	19 1	partie			

				State of Marylai				_	_	o.	
		•	1 - State Registrar		Ce	rtificate of	Death		Reg. No.	04	16718
	Dhysisi		1. Decedent's Name (First, Middle, Last)	2 01				2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic	al	Elizabeth t.		ICHFI			05		004.	13 10 PM
	Examin		4a. Facility Name (If not institution, give si			4b. City, Town,			4c. County		
			North Arandel Hus 5. Social Security Number 6. Sex	7. Age (In yrs	last hirthday			MARYLAND Hrs. 8. Date of B			undel place (State or Foreign
	Funeral Director		217-26-0558	м 2×F 7. Аде (117)13	Yrs.	Months Days		Nov 1	9, Year) 1930	Mar	yland
	ס		Usual Residence of Decedent								
	arylan show	ايا	Maryland Anne Arui		ity, Town or L Pas	sadena				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	Director				10f. Zip Code			10g. Citizen of	What Cour	
	I within 72 hours after death with the Maryland jiene Than "natural", or Items 23s or 28s-f show The Medical Examinatings the multified at		10e. Street and Number 127 Sandy	Beach Drive		101. Zip Code	21122		USA	What oou	iuy:
	death	Funeral	11. Marital Status	Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of	Hispanic Origin	? (Specify Yes or Nuerto Rican, etc.)	lo- 14. Rac	ce - Americ	
_	or ite	Fur	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2 ☑ No		uerto micari, etc.)	Specif		nite
12-003e	hours after tural', or Ite	d by	3 Widowed 4 Divorced	Year or Dates:	100 December 1						
ភ	"nati	lete	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	ipation e during most of ed)	working	16b. Kind of B		•
7	filed within 72 Hygiene. Her than "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker			Housewi	.fe &	Mother
land	e filec al Hyg I othe vent,	Bec	17. Father's Name (First, Middle, Last)	John Krach				Name (First, Middl	<sup>le, Maiden Sumai</sup> Johann	ne)	
	should b	To									
Mary	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship (Type Philip Joseph Bla	nchfield (hu	19b. Mail (shand	ing Address <i>(Str</i> ee 127 Sai	ndy Beac	r Rural Route Num ch Dr., P	ber, City or Town asadena ,	, State, Zip Md •	21122
	s 1 and the Heal		20a. Method of Disposition	20b.	Place of Disp	osition (Name of matory or other pla ran's Ce	ace)	Date	20c. Location	- City or To	own, State
Ë	Page nt: If iry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Mo	l. Vete	ran's Ce	métery	5/25/04	Crowns	ville	, Md.
Baltimore,	permit. Departm Importa any inju		21. Signature of Fureral Service License	• Kevin E Ecl	cer 🕺	2541 Myuh	ess of Facility	Funeral	Home, P	.A.	2020-00-00
n	80 2 2 9		y n				-	Funeral Pasade		, 2	1122
H			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	ath. Do not er	ter the mode of dy	ing, such as cal	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	Coler	ary e	jusad	e long	-		
	Examiner			1266		es de m	0 807	6			
		ner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		erdiom					
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Hyperte		arteriox	Caro tra	cardiogn	Sulardis	eise	
760,	icate be executed physician and s the burial-transit	calEx	resulting in assettly East	Due/to/(or as a conse	quence oi):						
687	physi s the I		d								
×	leath certificate attending phy I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregi					23d. Da	ate of delive	өгу
m ·	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnan □ Other (specify)	cy		Me	onth	Day Year
о. О	The law requires that the death certifica ate has been signed by the attending ph page 2 should be defached for use as th	Physician/Med	9 Unknown		** * *			one Die	I tabana was ass	4-7h	ha assure of death?
	res th signed	by	Part II. Other significant conditions con	tributing to death but not re	sutting in the	anderlying cause g	iven in Paπ I. A	230.010	Yes 2 No		he cause of death?
Records,	w require been signated should to	Completed	Diobets Mellits type advanced Chronic of BODP (Brondnolitis of per phenol VA) sula 25. Was case referred to medical	renal kilyne	the	DO TO S	7	24a. Wa			
Sec	has t	mpl	BONP (Brondielitis of	b/itenens)	44 DUT	wood in	2	24a. vve	opsy formed?	prior to co death?	opsy findings available impletion of cause of
	ificate or, pa		25. Was case referred to medical	a disense, R	ecent p	yo cardist &	SE Place of	1 ☐ Yes Death (Check only		1 🗆 Yes	2 No
5	/sicia s cert directe	To Be	avaminar?	oneital:				ng Home 5 Re		ner (Specit	5/)
0	er thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injury		ury at ork?		how injury occur		
Sion	endin sath. or: Af he fur	atlc	2 Accident investigation			M 1[	Tes 2□No				
Division of	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, s cify)	treet, factory, office	Ð	28f. Location City or T	(Street and Num own, State)	ber or Rura	al Route Number,
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1X Certifying Phys	sician: To the best of my k	nowledge, dea	th occurred at the	time, date and p	lace, and due to th	e cause(s) and m	anner as s	tated.
	ne Hos 124 h ne Fur sletely	Medical		ner: On the basis of examinand manner stated.							
	To th withir To th comp	M	29b. Signature and title of certifier	10			nse number		29d. Date signe		
)	/)		En Man of	onto Me	7	D.	3722	9	05	22 3	2004
	4		30. Name and address of person who co ANA MARIA MARTINE	mpleted cause of death (Ite	эт 23а) (Туре	Print)	, Pa.	dena M	1 2/122		
	Sta	ata		32. Registrar's Sign	nature		9 THJA	HENA M	21166		
فيد ا	Regist		31. Date filed (Month, Day, Year) MAY 2 6 2004	Sanger	19 1	parket					

		1	State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Maryland / Department of Registration   126 PER PHY 0831 5/26/04   Gertificate of Registration   126 PER PHY 0831 5/26/04   Column   126 PER PHY 0831 5/26/04   Column   126 PER PHY 0831 5/26/04   Column   126 PER PHY 0831 5/26/04   Column   126 PER PHY 08			ne No. 2004	16719
Ė	Physicia	an	1. Decedent's Name (First, Middle, Last)  CHARLES HARVEY BROWN, SR	1	2. Date of Death Month May 19,	Day Year 2004	3. Time of Death 2:15P M
,	/Medic Examin			n, or Location of Death imore		4c. County of Death N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye Months Day		8. Date of Birth (Month, Dey, Ye May 25,	ear) Cour	lace (State or Foreign ltry) land
	Maryland e-f show	tor	Usual Residence of Decedent  10a. State			1	0d. Inside City Limits 1 🖾 Yes 2 🗆 No
	h with the 23a or 28	al Director	10e. Street and Number 1117 Ward Street	21230	10g.	USA	ntry?
036	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "natural", or Items 23s or 28s-f show eurnatic event, the Madical Examina must be natified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:  13. Was Decedent 0 If Yes, specify 0 1 Yes 2 No If Yes or Dates:	of Hispanic Origin? (Specular, Mexican, Puerto No <i>Specify:</i>	acify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
Maryland 21215-0036	within 72 hou ene. then "natura ine Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	one during most of worki	ing	b. Kind of Business/In Warehouse	dustry
land 2	0 - 0 5	To Be Co	17. Father's Name (First, Middle, Last) Olaf H. Brown		d A. Rusk		
	and 2 should ealth and Men n 27 Is marke er treumatic	-	19a. Informant's Name/Relationship (Type, Print) Thomas A. Brown, Sr. (Brother)  19b. Mailing Address (Str. 844 Braesid	eet and Number or Rura le Rd., Bal	a <i>l Route Number, C</i> timore, M	ity or Town, State, Zip d. 21229	Code)
Baltimore,	Pages 1 nent of Ho ant: If Iter ury or oth		20a. Method of Disposition  1  Burial 2 X Cremation 3 Removal from State  1  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other Bayview Cremato:	ry, Inc. 5/	′22/04 Ba	altimore, l	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee Kevin E Ecker McCully—130 E. F.	Polyniak Fu ort Ave., B	Baltimore,	Md. 212	30 Approximate
8760,	Certificate be executed and holding physicien and pringing transit as the burial-transit	dical Examiner	immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a construence of):	y fa	ilur	R	6 monk
.O. Box 6	death certif e attending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \  \text{Yes} 2 \  \text{No} \\ 9 \  \text{Unknown} \\ \end{align*} 23c. If yes, outcome of pregnancy 1 \  \text{Live birth} 2 \  \text{Fetal death} \\ 4 \  \text{Pregnant at time of death} \\ 9 \  \text{Unknown} \\ \end{align*} 3 \  \text{Ectopic pregnancy} \\ 5 \  \text{Other (specify)} \\ 9 \  \text{Unknown} \\ \end{align*}			23d. Date of delive Month	ery Day Year
<u>α</u>	Se G	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		cco use contribute to t	4.4
Vital Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performe 1 Yes 2	prior to co	ppsy findings available impletion of cause of 24 No
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Yes 2   No	26. Place of Deat Other: 4 Nursing Ho	h (Check only one)	ce 6 Other (Special	(v)
on of	ding Phys h. After this funeral di	ation: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury	Injury at Work? 1 Yes 2 No	28d. Describe how		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certifica	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	fice	28f. Location (Stree City or Town,	et and Number or Run State)	al Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the description of the basis of examination and/or investigation, in rand manner stated.	ne time, date and place, my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)
	To the within To the comp	M	290. Signature and title of the state of the	cense number  D 0055		Date signed (Month,	
	1)			D 0055 5, GREE	N Bair	MORE M	02/201
*	St Regist	ate rar	MAY 2 6 2004  Shows & Signature  MAY 2 6 2004	2			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? [] [] [ 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day Month **Physician** MAY 9:30 AM Frank W. Burgess, Jr. 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1445 Watts Avenue Severn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 18, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Days Months Hours 1 X M 2 T F 217 05 6718 85 Yrs. Jan. 1919 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Anne Arundel Severn Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1445 Watts Avenue 21144 U.S. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Fire Chief Anne Arundel County 12th Pages 1 and 2 should be filed vent of Health and Mental Hygie int; if item 27 is marked other? traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Rost Frank W. Burgess, Sr. ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Georgette Bluyers / Daughter South Ferndale, Maryland 21061 108 First Avenue other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State õ permit. Pagé Department d Important: If eny injury or once. Bayview Crematory 5/22/2004 Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 tramerous 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician OLON CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit nding physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed certificate 20 No 1 ☐ Yes Division of Vital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 1 Yes 2 10 10 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 / Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Cartifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 21, 2004 D57531 30. Name and address of part on who completed cause of death (Item 23a) (Type, Print) 8601 Nego Veterans clernotte no

State Registrar

31. Date filed (M)

DHMH 17 Rev 1/2001

32. Registrar's Signature

2004

Robert W. Bolkoski 04-03481 DOS

unpend item#23a,27,28a-f,PFR ME,G832,6/22/04eg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oos			For State Registrar	State of Mai	ryland /	Depa Cer	artment <i>rtificate</i>	t of H	ealth a Death	ınd M		gien Reg. N		16721
	Physici	an	1. Decedent's Name (First, Middle, Last)  Robert W.	Borkosl	ri.				-		2. Date of De Month May 2.	ath Da		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give si Park Plaza Motel F	treet and number)			Bro	okly				44	c. County of Death Anne Ar	undel
	Funeral Director		5. Social Security Number 213-64-2179  Usual Residence of Decedent	M 2□F 7. Age	(In yrs. last i	birthday) Yrs.	If Under Months	1 Year Days	If Under:	Min.	8. Date of Bir (Month, Da 09-30-	y, Year		place (State or Foreign ntry) Land
	e-f show	ctor	10a. State 10b. County  Maryland Anne Arun		10c. City, To Brook		Park							10d. Inside City Limits 1 ☐ Yes 2 No
	with the	I Dire	10e. Street and Number 317 Camrose Ave.				10f. Zip	Code 1225				•	itizen of What Courted State	•
980	be tiled within 72 hours after death with the Maryland ital Hygiene. So other then "naturel", or items 23a or 28e-f show event, it s Marical Existrical must be notified at	by Funeral Director		2. Was Decedent Ev Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: V	)	1	Was Deced If Yes, spec		spanic Orion, Mexican	gin? (Spe , Puerto	ocify Yes or No Rican, etc.)	)-	14. Race - Americ Black, White, Specify: W	
Maryland 21215-0036	within 72 hor ene. then "natur	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+		(Give life.	dent's Usua kind of wor DO NOT us Sales	rk done a se retired,	luring mosi )	t of worki	ng		Kind of Business/In	
land 2	should be filed and Mental Hygin rmarked other umatic event, II	To Be Co	12 years 17. Father's Name (First, Middle, Last)  Joseph B. Borkoski						18. Mothe	rain	(First, Middle e J. Sp	, Maide orin	n Sumame) ger	
Mar	0 0 0 0		19a. Informant's Name/Relationship (Type Lorraine J. Borkos								more, Numb		or Town, State, Zin	o Code) 225
ď	of Health of Health if item 27 or other tro		20a. Method of Disposition  1 □ Burial 2 Cremation 3 □ Re	amoval from State	ceme	itery, crei	sition (Nan	ther plac			ate		Location - City or To	
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot		1 Burial 2 Cremation 3 R. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	-	-	25	Cremat 2. Name an Culls	d Addres	s of Facilit	v	2004 neral H	_	timore, P.A. e, P.A. e, Maryla	
1760,	Physician /Medical Examiner	ical Examiner	23a. Pagn. Enter the disease, or complished or heart billure. List only on disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cocaine In  Due to (or as a	toxicat	ce of):	er the mod	e of dying	g, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Batween Onset and Death
P.O. Box 687	death certificate e attending phys od for use as the	Physician/Medic	in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal death	ath 3[ n 5[	⊒Ectopic pr ⊒ Other <i>(sp</i>	ecify)					23d. Date of deliv	Day Year
Records, F	v requires that been signed should be de	Completed by F	Part II. Other significant conditions con	tributing to death bu	t not resultin	g in the u	inderlying c	ause give	en in Part I		1 🗆 24a. Was	Yes	2 No 3 Prol	bably 4 Unknown
	The ate h page		25. Was case referred to medical						26 Place	of Death	auto perf Yes	ormed?	death?	ompletion of cause of 2□ No
ion of Vital	ding Phys	ation; To Be	examiner?  1 X Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1  Inpatier  28a. Date of Injury (Month, Day)  5/23/04	Year) 28	Outpatie b. Time o Injury	of 2	8c. Injun Worl	er: 4□Nu	ırsing Ho		idence	6 <b>≨</b> Other ( <i>Speci</i> jury occurred	ib) at scene
Division	i i te	Certification:	3 ☐ Suicide 6 IXCould not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	(Specify)						City or To	wn, Sta	4 10th St.,	Brooklyn, MD
	To the Hospitel within 24 hours a To the Funerel Completely filled in	edicai	29a. Certifier  (Check only one)  1 ☐ Certifying Physical Examination  2 ☑ Medical Examination	sician: To the best o ner: On the basis of and manner stat	examination	dge, deal and/or ir	th occurred rvestigation	at the tin	ne, date ar pinion, dea	nd place, ith occurr	and due to the ed at the time	cause( date a	(s) and manner as s nd place, and due t	stated. to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	MO			290		ME				Date signed (Month, 200)	
			30. Na la and person who co	KE, MC	ath (Item 23		Print)	1 Pe	enn St	reet	, Balt	imoı	re, Maryl	and 21201
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 2 6 2004	2. Registra	r's Signature	dos	A.							

Clipha, arris At known as: Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please 7	Гуре or Pr	int in Black	Indelik	ole Ink.	. Ensure Al	II Copies	Are L	.egible.		
		1 = For State Amend Items 5	State of N 10e per F	Maryland / D H,6831,05/2	epartmo	ent of F ate of	lealth and M <i>Death</i>	1ental Hy	giene Reg. No.	2004	16722	
Physicia	an	1. Decedent's Name (First, Middle, Last		Charl			-	2. Date of De Month	Day	Year	3. Time of Death	
/Medic	al	4a. Facility Name (If not institution, give			4b. C	ity, Town, o	or Location of Death	May	18 4c. 0	2004 County of Death	04.40 A.	
Examin	er	5: Social Security Number 6. Se			I		1timore			N/A		
Funeral Director		5. Social Security Number 5. Se 21 9 – 26 – <b>1899</b>	X 27.		rs. If Un Mont	hs Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug.	15 ,	1927 N	place (State or Foreign ntry) 1. Car	
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					1	Od. Inside City Limits	
er death with the Maryland Items 23e or 28e-f show ner must be mutified at	tor	Naryland		Balt	imore	<u> </u>			1 <del>/2</del> Y			
th the	Director	10e. Street and Number			10f.	Zip Code			10g. Citiz	en of What Cour	ntry?	
ath wi	rai	4640 Reisterst				217				ISA		
ē 2 2 3	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Yes 2	s?	13. Was De If Yes,	specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	1	<ol> <li>Race - Americ Black, White,</li> </ol>		
a 0 5	Completed by F	Widowed 4 Divorced	If Yes, Give Year or Date	-	1 □ Ye	s 22 No	Specify:			Specify Blace	li	
72 hours naturel', dical Exa		15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a.	Decedent's l (Give kind of	work done	during most of work	ing	16b. Kin	d of Business/In	dustry	
- 2 30	mpi	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. DO NO	Tuse retire	s home		Ridg	6660	Monor	
S should be filed within and Mental Hygiene. Is marked other then eumatic event, the M	Be Co	17. Father's Name (First, Middle, Last)		7,07	sing	7730.	18. Mother's Name					
Alental Alental rked tic ev	To B	ENON NICHO	Lson				ELVIR	_				
2 should and Mer is marke eumatic		19a. Informant's Name/Relationship (T)	ype, Print)	19b.	Mailing Add	ress (Street	and Number or Run	al Route Numb	er, City or	Town, State, Zip	Code) 21229	
1 and Health em 27 ther to	1	LINDBURG Clinte 20a. Method of Disposition	7347	20h Place of	Disposition /	Name of		Date	20c Loc	ation - City or To	own State	
Pages nent of I ont: If It		Burial 2 Cremation 3 1		te cemeter	/	7-	/ 5/2	2/64	Lugge	carr	Mary long	
그 든 말 금 .		21. Signature of Funeral Service Licens		200000	22. Name	and Addre	ess of Facility C 4	ATMA	~ A	Jane's	And Who	
Depa Impo any ii		Leing Horn			BMAL	us, h	rd gal	LEAS			stad War	
		23a. Part1 Enter the disease, or comp shock, or heaft failure. List only of	ne cause on each	n line.	ot enter the a	mode of dyir	ng, such as cardiac				Approximate Interval Between Onset and Death	
Pnysician   /Medical		tramediate Cause (Final disease or condition resulting in death)	a	Myocard	al I	nfarc	tion					
Examiner		Lamediate Cause (Final disease or condition resulting in death)  a										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthying Cause (Disease or injury								7		
ecuted ind transit	aminer	Cause (Disease or injury that initiated events resulting in death) Last	c									
be exec sicien an burial-tr	ai Ex	resulting in ocality base	Due to (or	as a consequence o	π);							
ficate p phys is the	edic		d									
teath certificate b attending physic I for use as the b	an/M	23b. was decedent pregnant	23c. If yes, outcor	me of pregnancy 2 Detail death	3 □Ectop	ic pregnanc	v		23	3d. Date of delive	*	
The law requires that the death certificate be exe site has been signed by the attending physicien ar bage 2 should be detached for use as the burial-t	by Physician/Medical	in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown		t at time of death	5 Other		·			Month	Day Year	
that the	, Ph	Part II. Other significant conditions co	ontributing to deat	h but not resulting in	the underlyi	ng cause giv	ven in Part I.	23e. Did t	obacco us	e contribute to the	he cause of death?	
w requires that been signed to should be deta		Congesti	ve Heart	+ Failure				10	Yes 2	No 3□ Prob	pably 4 Winknown	
aw rec s bee	Completed	Diabetes	. Mell;	f Failure fus				24a. Was		24b. Were auto	ppsy findings available impletion of cause of	
	Com								rmed2	death?		
i <b>icien:</b> Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			O++	26. Place of Deat					
Phys r this ral dir	: To	1 ☐ Yes 2 ☑ No  27. Manper of Death	28a. Date of I	atient 2 ER/Out	ime of	28c. Inju	ry at	ome 5 Resi 28d. Describe		Other (Specif	(y)	
nding ith. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year) Ir	nju <i>r</i> y M	Wo 1 □	rk? ]Yes 2 No					
To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286, Place of	Injury - At home, far etc. (Specify)	rm, street, fac	ctory, office		28f. Location ( City or To		Number or Rura	al Route Number,	
spitel cours at serel Durs at serel Dilled in		29a, Certifier 1 Certifying Phy	vsician: To the he	est of mv knowledge	, death occur	rred at the ti	me, date and place	and due to the	cause(s) :	and manner as s	tated.	
ne Hos ne Fur	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.					opinion, death occur	leath occurred at the time, date and place, and due to the cause(s)					
To the To the To the Comp	Me	29b. Signature and title of certifier				29c. License number 29d. Date signed (Month, Day, Year)				Day, Year)		

State Registrar

Chad J. Hansen
31. Date filed (Month, Day, Year) MAY 2 6 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

M.D.

parks

Belvedere

D59062

Ave.

Baltimore

 $M\Delta$ 

May 18, 2004

			State of Maryland / Department of He	ealth and Me		ene, o o	16700
		•	1- State Registrar Certificate of Do			g. No.	16/23
	Physici	an	Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	Josie Frances Cunningham  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo		May 24,	2004 4c. County of Deal	10:12 pm h
			Franklin Square Hospital Rossville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		Date of Righ	Baltimor	
	Funeral Director			Hours Min.	Date of Birth (Month, Day, ) 7/25/192	Ye <i>ar)</i>	thplace (State or Foreign buntry)
	pup *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryla	tor	Maryland Baltimore Perry Hall				1 ☐ Yes 2 XNo
	th the or 28a g.noti	Director	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Co	ountry?
	ath wi	rai	9208 Cowenton Avenue 21128			J. S. A.	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural; or itama 23a or 28a-f show injury or other traumatic event, the Medical Evantian must be notified at injury or other traumatic event, the Medical Evantian must be notified at 9.	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No  If Yes, Give Year or Dates:  13. Was Decedent of Hisp If Yes, specify Cuban,  1 □ Yes 2 ☒ No	panic Origin? (Specif , Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.
9	2 hou		15 Decedent's Education 16a Decedent's Usual Occupation	ion	16	6b. Kind of Business	Inite Industry
21215-0036	within 7 lene. than "n	Completed	(Specify only highest grade completed)  [Give kind of work done durn life. DO NOT use retired]  [Give kind of work done durn life. DO NOT use retired]	ring most of working			
	filed w Hygies sthar ti	e Co	6 Homemaker 17. Father's Name (First, Middle, Last) 18	18. Mother's Name (F		Own Home	
Maryland	lid be fental rkad o	To B		Nellie	Simmo	ons	
lary	2 shot and N is ma	,-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and	d Number or Rural F			Zip Code)
	1 and Health em 27 thar tr		Carol Jean Sheets (Daughter) 9208 Cowenton A  20a. Method of Disposition 20b. Place of Disposition (Name of	Dat		Ll, Maryla Oc. Location - City or	
nor	Pages nent of I int: If it		A Burial 2 □ Cramation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Cometery, crematory or other place)  Holly Hill Memorial	1 3/2//2	2004		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address, Bruzdzinski		Homo Di	altimore,	Maryland
Ω_	Dep impe		1/1/2/01/ (' a)/2/1/20 >C   140/ Old Fa	astern Ave	enue Es	ssex. Marv	land 21221
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac or r	respiratory arres	it,	Approximate Interval Between Onset <sub>k</sub> and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	rhoje			1 day
	Examiner		Hyberton sin				40 years
	ed sit	iner	Sequentially list conditions, any, leading to min-solate cause. Enter Underlying Cause (Disease or injury	-1.			(84000
	be executed slcian and burial-transit	Examiner	that initiated events c. Link Self configuration of the configuration of	Juler			60 years
120	9 % 9	cai	d.				
x 68	ertifica ling ph	Med	IF FEMALE:				
Вох	that the death certifica ed by the attending ph detached for use as th	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No   23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)			23d. Date of del Month	ivery Day Year
0.	it the d by the tached	hysi	9 Unknown				
Records, P	sign sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part J.			o the cause of death?
9	e law requ has been ge 2 shoult	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
E B		Con			performe	ad? death? ∑No 1 ☐ Yes	
Vital	Physician: Th this certificate ral director, pag	o Be	examiner? V. Hospital: Other	26. Place of Death (		ce 6 ☐ Other (Spe	-4.1
of		-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury a		d. Describe how		city)
sior	Attanding ir death. actor: Afte by the fune	catio	2 Accident investigation M 1 Yes	es 2 No			
Division	al or Attand after death Diractor: d in by the	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281	t. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospital or Attens within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	, date and place, and nion, death occurred	d due to the cau at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License n	number	290	d. Date signed (Monta	h, Day, Year)
•	,		Presa Culasi DS	4034	1	May 25	2004
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MEETA GULATI, 9649 BELAIR ROA	10, 212	36		
	Sta Registr	. •	31. Date filed (Month, Day, Year) MAY 2 6 2004  \$2. Registrar's Signature  Aparks				

State of Maryland / Department of Health and Mental Hygiene? 16726 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 24, 2004 Physician Year Keith Cullison 1:30 aM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3611 Red Rose Farm Road Bowleys Ouarters Baltimore If Under 1 Year If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**⊠**₩ 2□F Yrs. 80 Director Pennsylvania 218 16 1276 March 22.1924 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Bowleys Quarters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 3611 Red Rose Farm Road 21220 or Items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 XX es 2 □ No WW II If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩o þ Specify. 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Curtis Cullison Frances Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna L. Cullison (Wife) 3611 Red Rose Farm Rd. Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
eny Injury or ot. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 5/26/2004 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A 1407 Old Eastern Avenue Essex, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Proysician disease or condition resulting in death) /Medical Due to for as a consequence of Examiner Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760 99 Physician/Medical as the IF FEMALE use a 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 80 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Tes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Other: 1 ☐ Yes 2 No ဂ္ 1 Inpatient 2 EP/Outpatient 3 DOA this tuneral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: Hospital or Attending Injury 1 Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 To the F and manner stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lucku 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUERBACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 6 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/200

MAY 2 6 2004

	1 - For State Registrar	State of Maryland / De	epartment of Health and M Certificate of Death	ental Hygien	e . 2004   672
Physician /Medical	Decedent's Name (First, Middle, Last)     David Stepher			2. Date of Death Month Di	ay Year 3. Time of Death 0315
Examiner	4a. Facility Name (If not institution, give to Upper Chesapeake	street and number) Medical Center	4b. City, Town, or Location of Death Bel Air	4	c. County of Death Harford
Funeral Director		M 2□F 90 Yrs	Months Days Hours Min.	(Month, Day, Year	1913 Maryland
with the Maryland a or 28a-f show the notified at	10a. State 10b. County  Maryland Harford  10e. Street and Number	10c. City, Town of Abingdo		10g C	10d. Inside City Limits 1 □ Yes 2 □ No Citizen of What Country?
iffer death with the rest of the man state of the man sta	19 Singer Road	12. Was Decedent Ever in U.S.	21009  13. Was Decedent of Hispanic Origin? (Sperif Yes, specify Cuban, Mexican, Puerto	ט	ISA 14. Race - American Indian,
tural, or iten	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1941-45	If Yes, specify Cuban, Mexican, Puerto I  1 ☐ Yes 2 ▼ No Specify:		Black, White, etc.  Specify:  USA
ygiene. ner than "natura t, the wedcal t	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	Coflege (1-4 or 5+)	ecedent's Usuaf Occupation Give kind of work done during most of worki fie. DO NOT use retired)	ng	Kind of Business/Industry
Theam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Wedical Examiner must be mailified at To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	Crowe		(First, Middle, Maide	S. Government on Surmame)  Dicson
tem 27 is mar	19a. Informant's Name/Relationship (7) Marian C. Crowe -	Wife 19	Mailing Address (Street and Number or Rura Singer Road, Abingdo	on, Maryla	and 21009
Importent: If item 27 any injury or other tr once.	20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	removal from State	crematory or other place)  Mem. Gardens 5/24	/04 Bel	Location - City or Town, State  Air, Maryland
any in	21. Signature of Funeral Service Licens	whennet	1317 Cokesbury Road	d, Abingdo	neral Home, P.A. on, Maryland 21009
nysician Medical xaminer	fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to (or as a consequence of)  b. Due to (or as a consequence of)	\$	i i espilatory arrest,	Interval Between Onset and Death
physician and the burial-transit		c	):		
d by the attending physical letached for use as the but letached for use as the but letached for use as the but letached for letached leta	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
		ontributing to death but not resulting in t	he underlying cause given in Part I.		o use contribute to the cause of death?
cate has been signe page 2 should be c	ANEMIA			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
his certified director.	25. Was case referred to medical examiner? 1 ☐ Yes 275.No	Hospital: 1  atient 2  ER/Outp	patient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how in	6 ☐Other (Specify)
or: Arter	27. Manner of Death  1	(Month, Day Year) Inf	ury Work? M 1 ☐ Yes 2 ☐ No		and Number or Rural Route Number,
within 24 hours after de To the Funeral Direct completely filled in by the Medical Certific	29a. Certifier Certifying Phy (Check only one)	/sician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time, date and place, for investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)
To the comple	29b. Signature and title of certifier	160	29c. License number HS5922	MA	Date signed (Month, Day, Year)
11	30. Name and address of person who d	completed cause of death (ftem 23a) (T	A	MD Z	1014.
State	******	32. Registrar's Signature	Sporks		

)		•	For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of rtificate of			giene Reg. Na200	4 16727
2	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month		3. Time of Death
	/Medi	al	Althera		Crox		and another of Dooth	MAY	20, 200	
	Examir	er	4a. Facility Name (If not institution, given 5206 SAYBROOK RO		,	BALTIM	or Location of Death	1	4c. County of [	Jeath
	Funeral	1	5. Social Security Number 6. S	Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.		th 9	Birthplace (State or Foreign
4	Director		214-62-5227 Usual Residence of Decedent	I □ M 2 □ X F	51 Yrs.	Months Days	Hours Min.	(Month, Da 12-25		Md.
	land w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	with the Maryland a or 28e-f show	tor	Md. NA		Balt	imore				1X Yes 2 No
	or 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	death wi		5206 Saybrook				1206		USA	
112	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or flems 23a or 28e-1 show other than "natural", or flems 23a or 28e-1 show event, the Medical Evander must be notified at	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑	?	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
21215-0036	hours after tural, or Ite	by	3 □ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1□Yes 2∏XNo	Specify:		Specify:	Black
5-0	72 ho 'natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occu kind of work done	during most of wor	king	16b. Kind of Busin	ess/Industry
121	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire /sical '	herapist		Varies	
	filed v Hygie Sther 1		12th grade 17. Father's Name (First, Middle, Last	<u>lyr.</u>	FIL	SICAL .		ne (First, Middle,	, Maiden Sumame)	
lan,	Aental Aental rkad c	To Be	Herbert	Bla	nchard		Mary		Ducket	t
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, traumatic		19a. Informant's Name/Relationship	_					er, City or Town, Sta	
	1 and 1ealt 1m 2 thar	1	Michael Croxton  20a. Method of Disposition	Son	5206 20b. Place of Dispo		ok Rd., Ba	altimore	20c. Location - City	206
Baltimore,	permit. Pages Department of t Important: If Its any injury or of once.		1 Described of Disposition  1 Described 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special Content of Content		cemetery, crei	natory or other pla	·			
H	mit. P bartme cortan injur.		21. gnature of Funeral Service Lice		King Mer	II. PK. Name and Addr		6-04 Balti	.more, Md.	town, Md. 21206
m	Departing Department of the partment of the pa		Joseph R.	Walter	1:11	March F.		1101 E	E. North A	ve.
Jul -	be executed XX ician and be executed be executed being incidentally in the property of the pro	Examiner	23a, Party. Enter the disease, or com- shock, or heart failure. List only Influence Cause (Final see or condition rulting in death)  Sequentially list conditions, if any, leading to immediate cause. Erner Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	Arterios  Due to (or as  Due to (or as	s a consequence of):  a consequence of):  a consequence of):				rrest,	Approximate Interval Between Onset and Death
P.O. Box 68760,	the death certificate y the attending phys ached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnand	ry		23d. Date of Month	delivery Day Year
	w requires that been signed E should be deta	ed by P	Part II. Other significant conditions of Systems 'K L	contributing to death I	out not resulting in the u		ven in Part I.			e to the cause of death?  Probably 4 Dunknown
Records,	e law has b	ompiet	Cachxia					24a. Was autop perfo 1  Yes	osy prior deat	e autopsy findings available to completion of cause of 1? Yes 2 \sum No
Vital	sician: The certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	one)	
of	this aldi	ျှ	1 Tyes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpati 28a. Date of Inj (Month, Da		28c. Inju Wo		ome 5 Resident	dence 6 MOther (S	Specify) SCENE
Divisi	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	e 28e. Place of In	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (S City or Ton	Street and Number o	r Rural Route Number,
	the Hospital or in 24 hours after the Funeral Direction pletely filled in I	Medical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best miner: On the basis of and manner st	of my knowledge, death of examination and/or in ated.	occurred at the trestigation, in my	me, date and place opinion, death occu	, and due to the orred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		101	29c. Licen	se number		29d. Date signed (M	onth, Day, Year)
	/		taling	ellah	75		.M.E.	Ŋ	MAY 21,200	)4
_	15		30. Name and address of person who ZABIULLA	H AL	-/	111 Penn	Street,	Baltimon	re, Maryla	and 21201
	Sta Registi	. 0	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	souls				

			For State Registrar	State of Maryland	Depa		ealth and	Mental Hy		001	16728
\$	Physici /Medio Examin	al	Decedent's Name (First, Middle, Las BETTY      As. Facility Name (If not institution, give	C.A street and number)	RTE	4b. City, Town, or		2. Date of De Month 05	Day Day 4c. Co	Year O'4- unty of Death	3. Time of Death 8 · 45 A M
	Funeral Director		213-90-1102		birthday) Yrs.	BACT If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bir	th ny, Year)	9. Birthp Cour Md.	RE CITY lace (State or Foreign try)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Medical Examinat meat be notified at ODGs.	To Be Completed by Funeral Director	Usuel Residence of Decedent  10a. State  10b. County  Md.  NA  10e. Street and Number  1301 N. Ellwood  11. Marital Status  15 Never Mamied 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest gra  Elementary/Secondary (0-12)  12th grade  17. Father's Name (First, Middle, Last)  Milton  19a. Informant's Name/Relationship (1)  Adele Carter  20a. Method of Disposition  1 Burial 2 Cremation 3 Chercify  21. Signature of Funeral Service Licen	12. Was Decedent Ever in U.S. Armed Forces?  1	Ball 13. 6a. Dece- (Give life. Se  102 9b. Mailin 102 9c of Dispository, creations, creations, creations, creations, creations)	timore  10f. Zip Code  21213  Was Decedent of Hilf Yes, specify Cuba  1  Yes	spanic Origin?  n, Mexican, Pu  Specify:  atton  18. Mother's N  Adele  and Number or  COOC AVE  9)  5-  ss of Facility	working  Hame (First, Middle  Rural Route Numb  ., Balti Date  -28-04  Balt	Lorie  Maiden Sui  Lorie, City or To  more, 20c. Locati  Ran imore,	of What Cour USA  Race - Americ Black, White, ecify: Bla of Business/Ini n Nurs: name) Price iwn, State, Zip Md. 2: on - City or To	an Indian, etc.  ack dustry  ing Home  Code) 1205 wn, State  Dwn, Md. 21201
760,	Physician //Medical Examiner	dical Examiner	23a. Part 1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	bilications that caused the death. If one cause on each line.  a. BOWEL P  Due to (or as a consequent of the consequent	ERF ce of):  LAR ce of):  O S	er the mode of dying	g, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death S DAYS  1 WEEK  10 YEARS
.O. Box 68	The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒(No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death	ath 3[	□Ectopic pregnancy □ Other (specify)			23d	Date of delive Month	ory Day Year
cords, P.	w requires that s been signed b should be deta	Completed by Pl	Part II. Dther significant conditions of A CUTE REY	ontributing to death but not resultin	-	nderlying cause gree	en in Part I.	1 🗆 24a. Was	Yes 2	o 3 Prob	ne cause of death?  ably 4 Unknown  psy findings available
Division of Vital Records,	or Attending Physician: flet death. Director: After this certifica in by the funeral director, p.	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death    Natural 5  Pending investigation 3  Suicide 6  Could not b determined  29a. Certifier 12 Certifying Ph	(Month, Day Year)	b. Time o Injury , farm, st	f 28c. Injury Work M 1 1	ar: 4 □ Nursin vat c? Yes 2 □ No	Death (Check only g Home 5 Res 28d. Describe 28f. Location ( City or To	one) idence 6  how injury or  (Street and N wn, State)	death? 1 Yes  Other (Specificurred	r) il Route Number,
•	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in 1	Medical	(Check only 2 Medical Examone)  29b. Signature and title of certifier  30. Name and address of person who	Illully M	and/or in	29c. License	oinion, death or	Courred at the time.	29d. Date s	oned (Month,	the cause(s)
DH	Sta Regist	rar	31. Date filed (Month, Day, Year) MAY 2 6 2004	32. Registrar's Signature	9	parkit	, rower	110   0			MO. 21287

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anthony Cheek State of Maryland / Department of Health and Mental Hygiene per me (833, 7/13/04 tas Reg. No. 04 - 3459**AKG** 1. Decedent's Name (First, Marithony Cheeks 2. Date of Death Month Day **Physician** Chook-**Anthony** 2004 6:02 P May 22, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 216 North Milton Avenue Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1**∑**M 2□F Days Hours Yrs Director 213-88-0592 Md Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h Counts "natural", or Itams 23a or 28a-f ehov digal Examinational be matified at Baltimore Yes 2 No Director NA Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 21224 216 N. Milton Ave. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. Black, White, etc. fited within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Varies Meat Cutter 12th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If tlam 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hood Cheeks Lucille Joseph 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7109 McLean Blvd., Baltimore, Md. JoAnn Cheeks Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State

Other (Specify) Voshell Mem. Pk. 5-28-04 Dundalk, Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Asthma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-68760 physician Physician/Medical the Box ( IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? ģ Month Year 5 ☐ Other (specify) 4 Pregnant at time of death P.O. the 9☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2□No Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) examiner Hospital: Other: 스 1XYes 2 No 4□ Nursing Home 5□ Residence 6XX Other (Specify) At SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 4 Certification: 1 Natural 5 Pending investigation death. 1 TYes 2 🗌 No 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide Vithin 24 hours. 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 MARYARITA 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Frank! MAY 2 6 2004 Registrar

		1	1 - State of Mar Registrar	•	artment of Health and rtificate of Death	Mental Hygier		16730
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)  FRANCIS L. CAR	RIKEI	3	2. Date of Death Month  A  2	Pay Year 2004	3. Time of Death
, 	Examin Funeral	er	0.000	(In yrs. last birthday)	4b. City, Town, or Location of Dea  WeSTMINS TC  If Under 1 Year   If Under 24 Hr  Months Days Hours Mir	S. 8. Date of Birth (Month, Day, Yea	4c. County of Death  CARLO  9. Birthpl  Coun	LL lace (State or Foreign try)
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo		JUNE 13 1		0d. Inside City Limits 1 ✓ Yes 2 □ No
	with the Ma ta or 28a-f i Lee notifile	I Director	10e. Street and Number 45 WASHINGTON B		nonster 101. Zip Code 21157	10g. (	Citizen of What Coun	•
36	n 72 hours after death with the Marylan "naturel", or liems 23a or 28a-f show cited Examinar must be inclifted at	by Funeral	11. Marital Status  12. Was Decedent Event armed Forces?  1 □ Never Married 2 Married   12. Was Decedent Event Event armed Forces?  1 ☑ Yes 2 □ No If Yes, Give.	ver in U.S. 13.	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 Yes 2 No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Americ Black, White, Specify:	
215-0036	filed within 72 hours after death with the Maryland Hygiene. the than 'naturel', or Items 23s or 28s-f show the, the Medical Examinar must be notified at	Completed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+	(Give	dent's Usual Occupation skind of work done during most of w DO NOT use retired)	orking	Kind of Business/Inc	
and 21	I be filed wit ntal Hygiene ed other the	Be	12 6  17. Father's Name (First, Middle, Last)  Ames Frenezic CA	eri Ker	DREIGN ALD  18. Mother's N.  Nellic	ame (First, Middle, Maid	len Sumame)	
2	and 2 shouk Beith and Me n 27 is mark er traumatic	2	19a. Informant's Name/Relationship (Type, Print) RICK CARRIKER / SON	19b. Maille 5416	ing Address (Street and Number or I	Pural Route Number, Cit VC ELDEN	y or Town, State, Zip Sbung M	Code) 10 21784
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, Its Medical once.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	CARROLL		15/2004 HA	Location - City or To	, mo
Ba	permil Depar Impor any ir		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, promplications that caused to shock, or heart failure. List only one cause on each line		6028 Sykesville	Road E		Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a	consequence of):	Lyelochypha:	itu Dise	ese	Onset and Death
8760,	cate be executed with the physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	mve			4 mis
.O. Box 68	ne death certifi the attending thed for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal death 3 [	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
٥.	w requires that the bean signed by should be detact	by	Part II. Other significant conditions contributing to death bu	t not resulting in the t	underlying cause given in Part I.		co use contribute to the	ne cause of death?
al Records,	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed 1 Yes 2	prior to co death?	psy findings available mpletion of cause of
n of Vital	ding Physician: T n. After this certificat funeral director, pa	on; To Be	25. Was case referred to medical examiner?  1  Yes 2 No	y 28b. Time	of 28c. Injury at Work?	Death (Check only one)  Graph Home 5 Residence  28d. Describe how i		m Assusted
Division	or Attenditer death	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	iry - At home, farm, s . <i>(Specify)</i>	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical C		examination and/or i	investigation, in my opinion, death or	ccurred at the time, date	and place, and due to	o the cause(s)
	To the Company	Σ		216	29c. License number	29d.	Date signed (Month,	n 2004 Day, Year) Day 2057
	s	ate			Sporks	we Were	uto, m	D, 21157
	Regis		MAY 2 6 2004	- 10	proces			

			1 - For State Registrar	State of Maryla	and / Dep		ealth and Me	•	ne 2004	1673
	Physici /Medic		1. Decedent's Name (First, Middle, I Ancilla G. Carr	•				2. Date of Death Month Lay 21, 2	Day Year 004	3. Time of Death 2:38 a M
	Examin		4a. Facility Name (If not institution, g Potomac Valley			4b. City, Town, or Rockvil	Location of Death		4c. County of Death Montgome1	cy
	Funeral Director		528-18-5500	Sex 7. Age (In y. 1   4   94	rs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. S	B. Date of Birth (Month, Day, Ye ept. 11,	<sup>ar)</sup> 1909 Nort	olace (State or Foreign LK) Dakota
	Maryland f ahow	tor	Usual Residence of Decedent	omery 10c.	City, Town or L				1	0d. Inside City Limits 1
	sa or 28a-	Funeral Director	10e. Street and Number 6307 Tilden Lane		-1.	10f. Zip Code 20852		10g.	Citizen of What Cour	-
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic avent, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Worklowed 4 Divorced	12. Was Decedent Ever in Armed Forces? ▼☑Yes 2 ☐ No 11 Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🗓 No	spanic Origin? (Spec n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	an Indian,
Baltimore, Maryland 21215-0036	d within 72 ho piene. ir than "natur the Medical	Completed	15. Decedent's (Specify only highest g	Education rade completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) omemaker	ition luring most of working )	165	Kind of Business/Ind	dustry
yland	should be filed vand Mental Hygie is markad other taumatic avent, III	To Be C	17. Father's Name (First, Middle, Lat Adolf Giovannoni					iovannon	Ĺ	,
, Mar	and 2 sh leaith and m 27 is m		19a. Informant's Name/Relationship Alfredo F. Capu	to/Nephew	630	7 Tilden	Lane, Roc	kville, N		
timore	permit. Pages 1 and 2 Department of Health a Important: If item 27 ti any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	B <sub>z</sub>	altimore	osition (Name of matory or other place controls Crematory	y at LP	25/04	Location - City or To	
Bali	Dermit Depar Impor any in		21. Signature & Funer II Service Lic	HOVa		Simple Tr Simple Tr 1040 Rock	Pak	Rockwi 1	Cremation	
	Physician /Medical Examiner		234. Pand. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	a. Advanced  Due to (or as a cons  Failure t	Dementi	.a	, such as cardiac or i	espiratory arrest,		Approximate Interval Between Onset and Death
3760,	ate be executed hysicien and he burial-transit	cal Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cons  d.						
Division of Vital Records, P.O. Box 68	The law requires that the death certificate the has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ≅ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)		-	23d. Date of delive, Month	ry Day Year
rds, P	quires that in signed t uld be det	þ	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause giver	n in Part J.	23e. Did tobacco	o use contribute to the	e cause of death? ably 4 Unknown
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\$ E	Physician: r this certifica ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2XXVo	Hospital: 1 ☐ Inpatient 2	□ EB/Outpatien	04	26. Place of Death		6 □Other (Specify,	
ion of		ertification; T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)		28c. Injury Work		d. Describe how inj		
Divis	tel or Attending Pt is after death. al Director: After th ed in by the funeral	Certific	3 Suicide 6 Could not determined	building, etc. (Spec	cify)	•		City or Town, Sta	•	
	Hospi 4 hou Funer ely fill	ledical	one)	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death nation and/or in	occurred at the time restigation, in my opi	e, date and place, and nion, death occurred	due to the cause( at the time, date a	(s) and manner as sta nd place, and due to	ited. the cause(s)
	To the vithin 2 To the complet		29b. Signature and title of certifier	S. Fram	em	29c. License D-59	number 9284	29d. D	May 21,	
	5X		30. Name and address person who Dr. Shahid St	completed couse of death (Ite	em 23a) (Type,		Silver Spr	ing, MD	20902	
	Star		31. Date filed (Month, Day, Year)	32. Fegistrar's Sign		low	·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 4 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:60 A M **Physician** /Medical astitution, give street and number wn, or Location of Death 4c. County of Death Examiner attimore Birthplace (State or Foreign Country) 5. Social Security Number Under 1 **Funeral** Days Hours Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Example must be notified at 1 Yes 2 □ No Directo 10g. Citizen of What Country? Be Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other ther Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suman Baltimore, permit. Pages 1
Department of H
Important: If ite
any injury or ot urial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Quant 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner this certificate has been signed by the attending physician and rai director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 **Y** No 1 Yes filled in by the funeral director, 25. Was case referred to-medical 26. Place of Death (Check only one) 2 No Other: 1 Tes Medical Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 25704 30. Name and address of d cause of death (Item 23a) (Type, Print)

Registrar

State

110

2 6 2004

31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death \*Physician 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Healthcare 5. Social Security Number paltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1933 -32-2847 1 M 2 □ F Months Days Hours Director Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f show traumetic evant, the Modical Executary found be notified at 1 Yes 2 No Director mD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SF าไลเ or items 23g a 1a08 Tarmuau Funeral 12. Was Decedent Ever in U.S. Armed Ecroes? 1 (DY6s. 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced Black "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within t of Health and Mental Hygiene.
If itam 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henson helma 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7197 Batto, MP 21208 comes brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date / 20c. Location - City or Town, State 1 Description 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or '4 □ Donation 5 □ Other (Specify)

21. Signat of Pineral Servic Liousse 22. Name and Address of Facility neral Service Liousee 21229 270 Tredhitton Ess Batto, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disea or condition resulting in death) Pnysician Arterio scleratic Coronary /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consacuence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): by the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an 1 ☐ Yes 27 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: Other: 4 \( \triangle \text{ Nursing Home} \) 5 \( \triangle \text{ Residence} \) 6 \( \triangle \text{Other} \( (Specify) \) 2 ER/Outpatient 3 DOA 9 1 ☐ Yes 2 No 1 🗌 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Diractor: After To the Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation death. 2 🗌 No 6 □ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day,

MAY 2 6 2004

22. Registrar's Signate

			For State Registrar	State of Marylar		artment of F		d Mental Hy	/giene Reg. No. 200	4 16734
	1		1. Decedent's Name (First, Middle, Last,	)				2. Date of D		3. Time of Death
>	Physici /Medic Examin	al	Elizabeth  4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of D	Month May	19 200 4c. County of D	4 18:30 M
18	LAGITIII	0	Upper Chesapeake M	Medical Center	r	Bel A	ir		Harfo	ord
	Funeral Director		Social Security Number     6. Security Number			If Under 1 Year Months Days	If Under 24	Min. (Month, D		Birthplace (State or Foreign Country)
	D .		Usual Residence of Decedent  10a. State 10b. County	100 0	ity, Town or Lo	cotion				10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show Jisal Exaciliar marite notified at	ctor	Pennsylvania Ches		vayne	- Cation				1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w	<u>a</u>	557 Park Ridge Dri			19087			USA	
	ltems	Funeral		12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin an, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	o- 14. Race - A Black, W	merican Indian, hite, etc.
5-0036	ours aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2💯 No	Specify:		Specify:	White
0	72 hou	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occup kind of work done	pation	Lundking	16b. Kind of Busine	
2121	9	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)			
	The second	S		2	Admir	istration			Title Co	mpany
Maryland	Q 5 Q ●	Be	17. Father's Name (First, Middle, Last)  John  J.	Doyle			18. Mother's Eliza		e, Maiden Sumame)	Creo cre
<u> </u>	d 2 should be th and Menta 7 is marked treumatic ev	2	19a. Informant's Name/Relationship (T)	_	10h Maili	na Addross /Ctroot			Perrier  ber, City or Town, State	Green
Ma	コピトリ								Pennsylva	
ē,	s 1 and 2 if Health item 27 other tr		Robert Doyle, MD.  20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place		Date Date	20c. Location - City	
Baltimore,	8 = 5		1 \( \overline{	temoval from State	•	Cemetery		01/04	West Consh	ohocken, PA
ati	permit. Pag Depa tmeni Important: any injury once.		21. Signature i Funeral & rvice Licens		2:	2. Name and Addre			Funeral Ho	
m	Depa Impo any in		Murles	mark	1	317 Cokes	sbury R	oad Ahir	ordon MD 2	
>	Physician		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that up the dealer cause of a line.	th. Do not en	er the mode of dyir	ig, such as car	on do	arrest,	Approximate Interval Between Opset and Death
	Medical Examiner  Assistan and be purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of must that initiated events resulting in death) Last	Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	quence of):	nemi.	a d	he to	Bleading	x 14 hours
68760	ficate be physicia is the bur	edical		d						
O' Box	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3[	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
Records, P.	uires that n signed t Id be deta	þ	Part II. Other significant conditions con	ero Selevor	/ -	nderlying cause giv	en in Part I.		1	to the cause of death?  Probably 4   Unknown
00	w require been significant	lete	Corch	in 11 Riller	- di	ique	,	24a. Wa	s an 24b. Were	autopsy findings available
al Re		Completed						1 Yes	ormed? death 2 No 1 Y	o completion of cause of ? es 2 \( \text{No} \)
Vital		o Be	25. Was case referred to medical examiner?  1*Section Yes 2 No	Hospital: 1 Annatient 2	750/0-1	. ac oo. Oth		Death (Check only		
on of	ding Phys h. After this funeral di	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	28c, Injur Wor	y at		idence 6 Other (S) how injury occurred	oecity)
Division	ol or Atten after deal Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	eet, factory, office			(Street and Number or own, State)	Rural Route Number,
	To the Hospitel or Attending Phwithin 24 hours atter death. To the Funerel Director: Atter th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Phy	sician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, deat ation and/or in	n occurred at the tir vestigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time	cause(s) and manner , date and place, and d	as stated. lue to the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier	10		29c. Licens			29d. Date signed (Mo	
		9	<b>*</b>	MD		Do	0566	07	May 19th	1, 2004
	9		30. Name and address of person who co		m 23a) (Туре,	Print) 2. S	ATWO	oD Rd.	BELAPR	mD 21014
	Sta . Registr	A 15	31. Date filed (Month, Day, Year) MAY 2, 6 2004	32. Registrar's Sign	ator	pouts				

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1830

December Amen Point Medical Card   Delta   D				1 - For State Registrar	State of N	Maryland		rtmen <i>tificat</i> e			and M		giene,	/	16735
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The property of the property o		Funeral	(	1 - 1			t birthday)					8. Date of Bird	b	9. Birt	hplace (State or Foreign
The Control of Contr		Director		013 20 01/3	1 □ M 2)X_XF	71	Yrs.	Months	Days	nours	MIII.	June 4	193	2 Per	nnsylvania
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Physician Modical Examiner    Modical Examiner   Mo	Balt	permit. Depart Import eny inj		MINEE	2464	Van	A-10	140 R	ockv:	ılle	Pike	Rockvi	llle,	mation MD 20	Center 0852
Privated   Medical Examiner   Metastatic Cancer   Due to (or as a consequence of):			(	23a. Part1. Enter the disease, or com sbock, or heart failure. List only	plications that cause one cause on each	ed the death. I line.	Do not ente	er the mode	e of dying	, such as	cardiac c	r respiratory ar	rest,		Interval Between
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Sequentially late conditions continuous properties of the part of				[											V
The first contribution of death) List    Country   Count			er	Sequentially list conditions, if any, leading to immediate	0										rears
The contribution of the co		cuted nd ransit	amir	that initiated events	c										
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	90	oe exe cian a urial-l	EX	resulting in death) Last	Due to (or a	s a consequen	ice of):								
State    State   Color	876	cate b physic	dlca	•	_ d										
State    State   Color	9 X	certifi nding use as	//We		23c. If yes, outcom	e of pregnancy	,					-	25	3d Date of del	ivon
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    All Notes   1	BG	death s atter d for u	ician	in the past 12 months?	1 Live birth	2 Fetal de	ath 3 🗌						2.		•
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The state of the s		es tha gned be de	by P	Part II. Other significant conditions of	contributing to death	but not resultin	ng in the un	derlying ca	use give	n in Part I.					
The state of the s	ord	een si	ted				-					XX	'es 2□	No 3□Pr	obably 4 Unknown
28. Place of Death (Check only one)  28. Date ol njury  Month, Day Year)  28. Date ol njury at work?  28. Place of Death (Check only one)  28. Date ol njury at work?  28. Date ol n	Sec.	e law has b	nple									autop	sv	prior to d	topsy findings available completion of cause of
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Eugne Libre, 6001 Muncaster Mill Road, Rockville, MD 20852  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	of	g Phy er this		27. Manner of Death			b. Time of								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Eugne Libre, 6001 Muncaster Mill Road, Rockville, MD 20852  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	io	andin path. pr: Aft	atlo	2 Accident investigation	n	ay rear)	injury				40				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Eugne Libre, 6001 Muncaster Mill Road, Rockville, MD 20852  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Divis	tel or Att	Certific		28e. Place of Ir	njury - At home etc. <i>(Specify)</i>	, farm, stre	et, factory,	, office		2			Number or Ru	ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Eugne Libre, 6001 Muncaster Mill Road, Rockville, MD 20852  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		the Hospi in 24 hour he Funer pletely fills	edicai	(Check only 2 Medicel Exer	niner: On the basis	of examination	dge, death and/or inv	occurred a estigation,	at the time in my opi	e, date <i>a</i> nd inion, deat	d place, a	and due to the o	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Eugne Libre, 6001 Muncaster Mill Road, Rockville, MD 20852  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To t To t		29b. Signature and title of certifier	KI	7		29c.	License					-	
Dr. Eugne Libre, 6001 Muncaster Mill Road, Rockville, MD 20852  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	7	17		2 ()	ZIL	ne	N		18	94.	20		Ma	y 21, 2	2004
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State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registra Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2004 DUNCAN KUTH **Physician** 9:14 PM GLORIA 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE CENTER HARBOR HOSPITAL | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 23, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🗹 F 218-22-9047 76 Vrs 1927 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show event, the Medical Examiner must be notified at Baltimore 1 Yes 2X No Maryland Anne Arundel Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 4126 Belle Grove Road 21225 USA or Items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status illed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "nt any injury or other traumatic event, Ite Medal once. College (1-4or 5+) Elementary/Secondary (0-12) Custodian Md. Paper Box Co. 10 17 Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Naoma Lowman Milburn Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William A. Duncan, Jr. (SON) 28 Hampton Rd., Linthicum, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5/26/04 Baltimore, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility McCully-Polyniak Funeral Home, P 130 E. Fort Ave., Baltimore, Md. 21. Signature of Funeral Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oriset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PULMONARY DISEASE EXACERBATION CHRONIC **Physician** /Medical Due to (or as a consequence of): DAYS **Examiner** MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner 4 DAYS To the Hospital or Attending Physician: The law requires that the death certificate be executed KENAL FAILURE use as the burial-transit and Due to (or as a consequence of): the attending physician Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, HYPERTENSION, HYPERLIPEDEMIA, 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown Be Completed peen VERIPHERAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform DISEASE VASCULAR 2 No 1 ☐ Yes 2 10 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 ☐ Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 16774 MAY 22 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANOVER STREET, BACTIMORE, MD-21225 ARCHANA MUDIVARIGH 3001 32. Registrar's Signature Registrar

			State of Maryl	-	artment of F			ne No.2004	16737
			1. Decedent's Name (First, Middle, Last)				2. Date of Death	D	3. Time of Death
	Physicia		Abigail Ellen Early			Ì	May 23, 2	Day Year	1:45 AMM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	7	4b. City, Town, o	r Location of Death		4c. County of Death	
	Examin	٠,	Harford Memorial Gardens		Havr	e de Grace	e	Harford	
	Funeral			yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthpl	ece (State or Foreign
	Director	П	041-42-7799 1□M 2ÅF 6	3 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 23,	1940 Conn	ecticut
	D.		Usual Residence of Decedent						
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I	e Ma	ę	Maryland Harford	Havre	de Grace				1 Tyes 2 XNo
C	or 28	Öre	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Count	try?
	ath w	Funeral Director	515 Warren St.			1078		USA	
3	r deg	nue	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
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	Ind 212- be filed within that Hygiene. or other than		17. Father's Name (First, Middle, Last)	CICI	ıcaı	18. Mother's Name	(First, Middle, Maid		onpany
	ylanc	To Be	Francis Martin Early			Evelvn	Marie 1	Franz	
7	farylan 2 should be 1 and Mentat 1 s markad 1 sumatic ev	۲	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street			ty or Town, State, Zip	Code)
10	altimore, Maryland 21215-0036 mil. Pages 1 and 2 should be filed within 72 hours alt partment of Health and Mental Hygiene. portant: If item 27 is marked other then "natural", or y injury or other treumatic event, Item Medical Eventer.		Benedict Schwartz /Personal	Rep. 211	1 Foley	Road, Havi	re de Gra	ce, MD 21	078
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10	nit. F artm ortar injur		21. Signature Funer Fervice Liganse	22	Name and Addre	etery 5-20 ss of Facility	5-04	el Air, Ma	ryrand
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	/Medical		disease or condition resulting in death)  a. Due to (or as a con	sequence of):	000	Tour		/	Control Control
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H	O. Box 68 he death certific r the attending pl ched for use as t	SICI	1 Yes 2 No 4 Pregnant at time		Other (specify)			Month (	Day Year
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$\nearrow$	of V Physic rthis co	To		2 ER/Outpatien		4   Italising Hon	ne 5 🗆 Residence	6 ☐Other (Specify)	
1	on of ding Phys After this funeral di	on:	27. Manner of Death 28a. Date of Injury  1 ☑Natural 5 ☐ Pending (Month, Day Yea	r) 28b. Time of Injury	Wor		28d. Describe how in	njury occurred	
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D	Divisic	ıtı	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp	t home, farm, stre ecify)	eet, factory, office	2	28f. Location (Street City or Town, St	and Number or Rural rate)	Route Number,
Ui	Division of Vita  To the Hospital or Attanding Physicien: within 24 hours after death.  To the Funaral Director: After this certifics completely filled in by the funeral director,		One Contillar (Distribution Physician T. 1997)	ke oud- d d d		no dota and the	and due to the	-(-)	
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	To tha within 2 To the comple!	Me	29b. Signature and title of certifier	7	29c. Licens	e number	29d.	Date signed (Month, D	ay, Year)
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	$\mathcal{T}$		30. Name and address of person who completed cause of deal?	Item 23a) (Type.	Printy 12.	deloz	SHIVTO	5 100 · 1	D. YA
	10		30 Name and address of person who completed cause of deap	oak,	office	horle	MARI	4/AND	21028
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's S	ignature	,				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rag. No. 2004 1- Stata Registra MEND ITEM #16a PER FH C831 5/26/04 CRP rtificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year 1:15 PM HENRY EISNER 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Baltimore Baltimore N/A If Under 1 Year If Under 24 Mrs. 8. Date of Birth (Month, Day, Year)
JULY 3, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Yrs. 83 217-14-6408 Director GERMANY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Show s 23e or 28a-f show 1 ☐ Yes 2 ☑ No Director BALTIMORE PIKESVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3623 ANTON FARMS ROAD 21208 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. the Medical Examiner 1 ☐ Never Married 2 🕅 Married Maryland 21215-0036 ò 1 ☐ Yes 2 🙀 No λq Specify: Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

CHATRMAN FMERITUS Elementary/Secondary (0-12) College (1-4or 5+) CHAIRMAN EMIRITUS EISNER COMMUNICATIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be WALTER EISNER ELSA STERN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3623 ANTON FARMS ROAD - PIKESVILLE, MD 21208 HARRIET EISNER / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ANSHE EMUNAH (AITZ CHAIM) 5/25/2004 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Deper Important any 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1 / Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Pulmonary disease or condition resulting in death) Edema 2 days /Medical Due to (or as a consequence of): Examiner Cardiomycrathy Sequentially list conditions 10 years cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The taw requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Physician/Medical use 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Sonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21- No 1 ☐ Yes 214 No 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Anatural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 M.D. May 23 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

West Belvedere Avinue, Baltimore, MD 2/2/5

M.D.

Hartman

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32. Registrar's Signature

В.

hysician	1. Decedent's Name (First, Middle, Last)			2. Date of I Month MAY	24, Day 200	3. Time of Dec 4 Year 12:55	
/Medical . Examiner	Jeremy Alan Forsythe  4a. Facility Name (If not institution, give street and number,		4b. City, Town, or Locat			ty of Death	
, Adjilli içi	1801 BEECHWOOD AVENUE		ESSEX	d=-0411=-		TIMORE	
eral tor	5. Social Security Number 6. Sex 7. And 217–17–5737 Social Residence of Decedent	ge (In yrs. last birthday) 28 Yrs.	If Under 1 Year If Ur Months Days Hou	ors Min. 8. Date of E. (Month, J. Feb. 2	1976	9. Birthplace (State or Fo Country) Maryland	oreign
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Moules Examination to items once.  To Be Completed by Funeral Director	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City L	
drermust be notified	Maryland Baltimore  10e. Street and Number	Essex	10f. Zip Code		10g Citizen of	1 ☐ Yes 2  What Country?	CM/10
i Dir	1801 Beechwood Avenue		21 221		U.S.A.		
nera	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispanio If Yes, specify Cuban, Me:	o Origin? (Specify Yes or I	No- 14. Ra Bla	ce - American Indian, ack, White, etc.	
by Fu	Never Married 2 Married TYes 2 13 Widowed 4 Divorced Year or Dates:	No	1 ☐ Yes XXNo Spe		Speci		
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To B	Gregory A. Forsythe		Ch	arlotte Har	rbin		
	19a. Informant's Name/Relationship (Type, Print)  Charlotte Wilson (mother)		-	umber or Rural Route Num	-		
	20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date	-	- City or Town, State	
	1 ☐ Burial <b>2XX</b> Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify)		matory or other place) Crematory	May 27,2004	1 Baltimo	ore, Maryland	d .
	21. Signature of Funeral Savice Licensee	22	2. Name and Address of F	acility	*		
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cian/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause inflat in dentying Cause (Disease or injury that initiated events c.	a consequence of):  a consequence of):  a consequence of):	ohol Intoxio				
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ledical	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best 2  Madical Exeminer: On the basis of and manner st	of examination and/or in					
6	29b. Signature and trie of certifier		29c. License numb	per	29d. Date signe	ed (Month, Day, Year)	
Med	> Allan /	death (Item 23a) (Type,	o.c.	M.E	MAY 2	24, 2004	

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ORIGINAL

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Physician   David   Lee   Fox   Fo	16740
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S. Social Security Number   5 Sec   7.3 sec	
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Delaware Kent Camden  10. Zip Code 19934  10. Zip Code	aryland
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Physician / Medical Examiner  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Physician / Medical Examiner  25	•
Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that inflated events resulting in death) Last  Cause (Disease or Injury that Injury at In	Approximate Interval Batte Interval Batte Onset and Death
O d to the contribution of	
24a. Was an autopsy performed?  25. Was case referred to medical examiner?  1 Yes 2 No 2 No 1 Yes 2 No 2 No 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N	lelivery Day Year
243. Was an autopsy performed?  1	to the cause of death?  Probably 4 Dunknown
	autopsy findings available o completion of cause of ?
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe now injury occurred Injury 28d. Describe now injury occurred Injury 28d. Describe now injury occurred 28d. Describe now injury occurred 28d. Describe now injury occurred 28d. Describe now injury occurred 28d. Describe now injury occurred	pecify)
Solution (Street and Number or building, etc. (Specify)  286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Rural Route Number,
29a. Certifier  29a. Certifier  29a. Certifier  (Check only (Check	as stated. ue to the cause(s)
= 29c License number 29d Date signed (Mi	nth, Dey, Year)
MAY, 20th	1,2004
296. Signature and title of certifier SURGIERY RESIDENT AT-2438946 MAY, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 EAST UNIVERSITY PARKWAY GRANDHI CHENCHERLAMUDI, DEPT. OF SURGIERY, BALTIMORE, MD-21218	1:
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 2 6 2004	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				1 - For State of Maryland / Department of Health and Me State of Maryland / Department of Health and Me Registrer AMEND TIEM #17 PER FH C831 5/26/04 CHErtificate of Death		jiene leg. No 2014	16741
		Physici		1. Decedent's Name (First, Middle, Last)  MARGARET ANN FTER	Date of Dea Month	200 00 40	3. Time of Death  2 - 40 P M
		/Medio Examir		4a. Facility Neme (If not institution, give street and number)  4b. City, Town, or Location of Death	3	4c. County of Deat	h
		Funeral		North Arundel Hospital Glen Burnie  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8	. Date of Birth	Anne A	hplace (State or Foreign
		Director		212-20-6688 1 □ M 2 ☑ F 81 Yrs. Months Days Hours Min.	June 1	9. Birt Co 1, 1922 Ma	ryland
		aryland ahow	70	10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Millersville			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
		with the M	Director	10e. Street and Number 1147 Cecil Avenue South 10f. Zip Code 21108	1	10g. Citizen of What Co	
٦		be filed within 72 hours after death with the Maryland tlat Hyglene. d other than "natural", or Items 23a or 28a-f ahow evant, fre Medicul Exprenent mast be trutified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Riu	fy Yes or No- can, etc.)		
ret	5-0036	72 hours after dea *natural', or Items dicul Eratr mattr	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify:			hite
2 6	21215-	within 72 lene. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  College (1-4or 5+) Homemaker		Housewife	•
Ma		e d la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last) Arthur Eden Fifer, Sr. (Husband)  Lillian			
2	Maryland	1 and 2 should be f Health and Mental I tam 27 is marked of other traumatic eva	To	AIOYIIS RECTIN HAMOND  19a. Informant's Name/Relationship (Type, Print)  Arthur Eden Fifer, Sr. (Husband) 1147 Cecil Ave., South	Route Number	r, City or Town, State, 2	
FE	Baltimore,	Pages 1 and nent of Healt int: If itam 2 iry or other		20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ Removal from State  1 □ Comparison 5 □ Other (Specify)  20b. Place of Disposition (Name of commetery, crematory or other place)  Cedar Hill Cemetery  5/25/2		20c. Location - City or Baltimore,	
IT	Balti	permit. Pages 'Department of H Important: If ite any injury or of		21. Signature of Fugeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Fur 3204 Mountain Rd., F	eral H Pasader	Home, P.A. na. Md. 2	1122
		Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. List only one cause on each line.	espiratory arr	rest,	Approximate Interval Between Onset and Death 30 Hours
		/Medical Examiner		resulting in death)  Due to (or as a consequence of):			30 110 110
		pe psi lisi	niner	Sequentially list conditions, if any, leading to immediate cause. Linter Unidentifying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):			
8	,097	ificate be executed g physician and as the burial-transit	cal Examiner	that initiated events ' c. Due to (or as a consequence of):			
	.89	- D 0	Medical	IF FEMALE:			
	P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funaral Diractor: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of del Month	ivery Day Year
	rds, P.	quires that I n signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
	Division of Vital Records,	The law red ate has bee page 2 sho	Completed		24a. Was a autops perform	sy prior to o med? death?	topsy findings available completion of cause of
	Vita	sician: certifica rector,	o Be	25. Was case referred to medical examiner?  1   Yes   2   No	Check only or	10)	
	on of	ing Phys I. After this funeral di	<b>-</b>	27. Manner of Death 1 Adatural 5 Pending   28a. Date of Injury (Month, Day Year)   28b. Time of Injury   28c. injury at Work?		ence 6 Other (Specow injury occurred	cify)
	Division	or Attenuafter deatl Diractor: in by the	Certification;	2 Accident	f. Location (Si City or Town	treet and Number or Ru n, State)	ıral Route Number,
	_	Hospital 24 hours Funaral stely filled	Medical Co	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and and manner stated.  2. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the c at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
		To the within To the comple	Me	29b. Signature and title of certifier  Ye		MAY 22	n. Day, Year)
		4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITA			61.
		Sta Registi	9 4	31. Date filed (Month, Day, Year) MAY 2 6 2004  Service Signature Society			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 22. May Robert Gresham Howlett 2004 10:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaPlata Charles <u>Genesis Eldercare LaPlata Ce</u>nter | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Months | Days | Hours | Min. | October 6,1913 | Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Months 230-01-8409 90 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Charles Maryland Waldorf Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20602 USA 70 Village Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hardware Store Salesman other permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy, Important: If item 27 Is marked othe any njury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Howlett Nettie Gresham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosemary Venable / Daughter 12902 Chalfont Ave, Fort Washington, Maryland 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory May 24,2004 Edgewater, Maryland ° 4 ☐ Donation 22. Name and Address of Facility
George P. Kalas Funeral Home, P.A.
6160 Oxon Hill Rd., Oxon Hill, Maryland 20745 21. Signature of Euleral Service Licensee entm Tant. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEMOSCLERUST **Physician** M AMERICA VI /Medical Due to (or as a consequence of): Examiner ERTINE 1 Secusatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that Ihe death certificate be executed EMENTY Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Nnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 2 No 1 TYes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient P 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 6 2004 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Augustus Russell 2004 20 11:16 A Mas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air | House 1 Year | House 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 24, 1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1**∑**M 2□F Mary Land 215-30-9939 71 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be notified at once. 1 ☐ Yes 2√ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1802 Redfield Road 21015 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 11 ☐ Yes 2 ☐ No If Aes, Give Year or Dates: 1951-55 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ⊋ No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Shipping/ Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver Trucking Line 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hall Russell Mildred Ellen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Hall - Wife 1802 Redfield Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem. 5/24/04 Jarrettsville, MD Ature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Priysician Myocardial disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 years oronany Securitilly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 honths?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Hall, Russell Augustus Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed; 1□ Yes 🛂 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: R/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death,
To the Funeral Director: After this completely filled in by the funeral dir 27. Man er of Death 28a. Date of Injury (Month, Day Yar) 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortific MD072167L 2004 20

nt

#252224

Revin 31. Date filed (Month, Day, Year) Madles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Upper Chesapeake Drive, Bel Air, MD 21014

MAY 2 6 2004

32. Registrar's Signature hormen

State

Registrar

			For State Registrar	State of Maryla		tment of He		ntal Hygien	ZUIIIs	16744
	Physici /Medic Examin	al	Decedent's Name (First, Middle, II      Johnne  4a. Facility Name (If not institution, g	W.	Hoo	Ker I Ib. City, Town, or Lo	II (	Date of Death Month May 18	ay Yeer	3. Time of Death
	Funeral Director			View Medical ( Sex 7. Age (In yr X M 20 F 5.	N. I. S. S. S. S. S. S. S. S. S. S. S. S. S.	If Under 1 Year		Date of Birth (Month, Day, Year		olace (State or Foreign ntry)
	Maryland e-f ehow	tor	10a. State 10b. County  Maryland Harfor		City, Town or Local  Belcamp	tion			1	0d. Inside City Limits
036	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or items 23e or 28e-f ehow event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number  1123 Belcamp Roa  11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?	U.S. 13. Wa		vanic Origin? (Specif Mexican, Puerto Ric Specify:		USA 14. Hace - Americ Black, White, Specify: Whit	can Indian, etc.
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-4or 5+)	(Give kir. life. DO		on ing most of working		Kind of Business/In	dustry
	uld be filed w fental Hygie rked other ti iic event, th	To Be Col	12 17. Father's Name (First, Middle, La Johnnie William	•	Cle		8. Mother's Name (F Mary Eve		n Surname)	Store
, Maryland	nd 2 shoutth and M 27 is mai	ĭ	19a. Informant's Name/Relationship Barbara England	(Type, Print) - Sister	611 1	Haylong A	Number or Rural R			1
Baltimore,	permit. Pages 1 ar Department of Hea Important: if item 's any njury or other once.		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Service Light)  21. Signature of Financial Service Light	city) An	Place of Disposition cometery, crematery, cr	ion (Name of tory or other place) Cemeterv Name and Address Comas Fur	May 21	20c. t , 2004 Hav	Location - City or To	own, State
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a Anoxic Due to (or as a conse	equence of):	the mode of dying,	such as cardiac or re	espiratory arrest,	Marylai	Approximate Interval Between Onset and Death  8 days
8760, A	ite be executed sysician and ne burial-transit	licai Examiner	S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CNYGNIC  Due to (or as a conso  Due to (or as a conso  d.	marces		neumonia	150050		3 months
P.O. Box 68	the death certifical / the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3 DEc	ctopic pregnancy Other (specify)			23d. Date of delive Month	ary Day Year
	law requires that the death as been signed by the atte 2 should be detached for	by	Part II. Other significant conditions Deep voin thy	•	-	-		23e. Did tobacco	use contribute to the	ne cause of death?
Il Reco	The ate h page	Completed		Type 2 diabet				24a. Was an autopsy performed? 1 Yes 2 N	prior to co	psy findings available mpletion of cause of
Division of Vital Records,	To the Hospital or Attanding Physician: Th within 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 2 Accident investigat 3 Suigida 6 Could not	28a. Date of Injury (Month, Day Year)		3 DOA Other: 28c. Injury a Work? M 1 Ye	t 28d	5 ☐ Residence . Describe how inju	ury occurred	
DIV	To the Hospital or Attendit within 24 hours after death. To the Funeral Director; A completely filled in by the fu		4  Homicide determine					City or Town, Star		
	o the Hos vithin 24 ho o the Fun ompletely i	Medical	(Check only one)  2 Medical Exone)  29b. Signature and title of certifier	eminer: On the basis of my k	nation and/or inves	stigation, in my opin	ion, death occurred	at the time, date ar	ate signed (Month,	the cause(s)
	A		30. Name and address of person wh	o completed cause of death (It	em 23a) (Type, Pri	16 'int)	- Anny		1ay 18,20	104
	Sta	te	Valeriani R. B. 31. Date filed (Month, Day, Year)	read, mp. 494	0 Eastern	n Avenue.	Baltmer	e,Mn	21224	
	Registr		MAY 2 6 2004	32. Registrar's Sig	nature dep	ocks/				

DONALD

HARWARD

	,		For State of Ma	aryland / Depa <i>Cer</i>	rtment of H			iene eg. No. 2004	16746
	Physici /Medic		Decedent's Name (First, Middle, Last)     HARRY		IRSCHOWI		2. Date of Dea Month		3. Time of Death
R	Examin		4a. Facility Name (If not institution, give street and number)	0 11	4b. City, Town, or		th	4c. County of Dea	
	Funeval		5. Social Security Number 6. Sex 7. Age	Baltimuse (In yrs. last birthday)	Bu Hi	If Under 24 Hrs	8. Date of Birth	9 Bir	N/A
	Funeral Director		212-09-1277 1X <sup>M 2□ F</sup>	96 Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day MAY 24	, 1908	thplace (State or Foreign ountry)  MD
	w.		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl	tor	MD N/A	BALT	IMORE				1 Ves 2 No
	th the or 28e	Director	10e. Street and Number	2,121	10f. Zip Code	<u> </u>	1	0g. Citizen of What C	ountry?
	ath wi	ralD	6958 MARSUE DRIVE #1-A			21215			U.S.A.
	ltems Inerr	Funeral	11. Marital Status  12. Was Decedent I Armed Forces?  1 Never Married 2 Married 1 MYes 2 N	Everin U.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
036	hours after death with the Maryland tural', or Items 23e or 28e-1 show at Exertinet must be notified at	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	10 WWII	☐ Yes 2X No	Specify:		Specify:	WHITE
5-0	72 hc	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occup	during most of wo	rking	16b. Kind of Business	/Industry
21215-0036	d within 72 hours after death with the Marylan Jiene. rthan "natural", or Items 23e or 28e-1 show The Medical Estaminat must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5	+) CLER	OO NOT use retired K	1)		STATE OF N	MARYLAND
1d 2	Hyg Hyg int,	a	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, i		
ylar	should be ind Mental s marked o umatic eve	To B	JOSEPH		CHOWITZ	REBEC			CAPLAN
Maryland	C1 (0 -2 (d)		19a. Informant's Name/Relationship (Type, Print)  DEVERA RESNICK / NIECE					RE, MD 212	
	s 1 and 3 of Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispos	sition (Name of	!		20c. Location - City or	
m0	Pages nent of ant: If its ury or o	,	1 X Burial 2 □ Cremation 3 □ Removal from State 14 □ Donation 5 □ Other (Specify)	BETH TFIL	natory`or other plac _OH_CEMET		5/2004	WOODLAWN	N. MD
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Funeral Service Licensee	22	. Name and Addres	ss of Facility S	OL LEVINS	ON & BROS.	, INC.
	₹0 = 9 a		23a. Part / Enter the disease, or complications that caused					IKESVILLE,	MD 21208 Approximate
ı	Dhamisis		shock, or heart failure. List dny one cause on each lin Immediate cause (Final	10.				951,	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	consequence of):	ul In	turcti	<i>i</i> ~		
П	Examiner		Sequentially list conditions, b.						
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	a consequence of):					
Ć	be executed ician and burial-transit	Exar	that initiated events	a consequence of):					
8760,	rate be executed obysician and the burial-transit	licai							
9	entifica ding pl	/Med	IF FEMALE:	of prognocou					
Вох	death certificate e attending phys od for use as the	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
P.O.	the ache	hysi	1   Yes 2   No 9   Unknown 9   Unknown						
	w requires that been signed b should be deta	by P	Part II. Other significant conditions contributing to death but		1	en in Part I.		pacco use contribute to	
orc	law requires as been sign 2 should be	eted	Conjestive Hear	r Fai	lore				robably 4 DHIKnown
Vital Records,	e la has	Completed					24a. Was a autops perforr	v prior to	utopsy findings available completion of cause of
tal	icien: Th certificate rector, pag	ø	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ath Check onlon	2 ☑ NO 1 ☐ Yes	2 No
of V	<b>78</b>	To B	examiner? 1 Tempatre	nt 2 ER/Outpatient	3 □ DOA Othe	er: 4 Nursing H	lome 5□Reside	ence 6 Other (Spe	cify)
o uc	ding P	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	28c. Injun Work		28d. Describe ho	w injury occurred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	ıry - At home, farm, stre		Yes 2 □ No	28f. Location (St	reet and Number or Ri	ural Route Number.
Ö	s after al Dire	Certification:	4 Homicide determined building, etc.	(Specify)			City or Towr	n, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dical	29a. Certifier (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	occurred at the timestigation, in my or	ne, date and place pinion, death occu	e, and due to the caurred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License			9d. Date signed (Mont	h, Day, Year)
•	.1		1 /hi 1/a	•	RE	500	00	MAY 20	1 2004
	N		30. Name and address of person who completed cause of de	<	Print)	:1,1	C R.	timore	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	HUSP	1441 8/	1291	41/101	
	Registr		MAY 2 6 2004 Selen	a B	parks				

HARRY HINSCHOWITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State	State of Ma	ryland /				ntal Hyg	iene	I got may I was
			Registrar			Certifica	te of Dea			g. No. 🗸 📗 📗	+ 6/4/
	Physici	an	Decedent's Name (First, Middle, L.	ast)		11. 1		2.	Date of Deati Month	Day Year	3. Time of Death
	/Medi		KAMMIYAH LE	ENIDA L.	58	HART			ray	23,300	
	Examir	ner ;	4a. Facility Name (If not institution, gi			4b. City	y, Town, or Location	on of Death		4c. County of Dec	
			1 000 1101111 20 0000	re Hospito			OSC da	der 24 Hrs.   8	Data of Dish	Baltin	
	Funeral			Sex 7. Age 1 M 2 X F	(In yrs. last	Yrs. Months			Date of Birth (Month, Day,	Year)	nthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent					14/	9422, <	MITA	CHIMA
	with the Maryland a or 28a-f show		10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
	Many fah	to	Marila d WA		BAL	imore					1 Yes 2 □ No
	r 28a-f	Director	10e. Street and Number		, , , , ,		ip Code		10	Og. Citizen of What C	Country?
	23a or	O	5941 DAY a	ACE ACE			2/20	6		451	4
	8 E	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Dec	edent of Hispanic ecify Cuban, Mexi	Origin? (Specif	y Yes or No-	14. Race - Am	
_ «	or its	3	Never Married 2☐ Married	1 Tes 2 No	)	1 Tes, sp	9.4		an, etc.)	Black, Wh	ite, etc.
کے کے		d by	3 Widowed 4 Divorced	Year or Dates:		12.103	2,40 0,000	y.		Spacify:	AMERICAN
·	within 72 hours effer dea ene. then "neturel", or items he Medical Examiner m	Completed	15. Decedent's to (Specify only highest g	Education rade completed)	16	Sa. Decedent's Us (Give kind of w	rork done during n	nost of working		16b. Kind of Busines	s/Industry
5.5	within lene. then	E D	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. DO NOT	1				
9 5	filed Hygie other		17. Father's Name (First, Middle, Las	it) · /		chifan-		other's Name /F	irst Middle A	Maiden Sumame)	
Babygi	ould be filed with Mental Hygiene arked other tha atic event, the	Be	Ban 1	LIBET			A	4/-	Para de	lar	
(T) \(\frac{5}{2}\)	2 should be filed and Mental Hygi ie marked other aumatic event,	2	19a. Informant's Name/Relationship	(Tyne Print)	1	9b Mailing Addre	ss (Street and Nu	mhar of Bural B	Toute Number	City or Town, State,	Zin (Cyte)
S, Babygirl	s 1 and 2 should be filed within 72 hou feel and Mental Hygiene. The strength of the feel and th		ASILCO Asulas	2 100.40	4	941 D	14 CUA16		12 15		/ /
	1 and Health tem 27		20a. Method of Disposition	(IIIETHER	20b. Place	of Disposition (N	ame of	Date		20c. Lastion - City of	r Town, State
5	0 0 = =		1 Burial 2 Cremation 3		ARP	tery crematory or	other place)	5/29/0-	4	rob 1 n	200 ( )
Boyle	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		ITAL	22 Name:	and Address of Fa	icility		Receives III	HRYTHAND
17-1 G	permit. Departimport Import eny inj		Marian	To. oo		MANC	4 mile	AKLACE	1 1 1	1711 -	ARMAND 21228
	一 一 有 後 一	-	23a. Partit. Enter the disease, or conshock, or heart failure. List only	mplications that caused to	he death. D	o not enter the mo	ode of dying, such	as cardiac or re	espiratory arre	ost,	Approximate
	Dhamisian		shock, or heart failure. List onli Immediate Cause (Final	b				1			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Massi Due to (or as a			rania	1 he	mor	rhage	12 hours
	Examiner			extre		~ · · · · · · · · · · · · · · · · · · ·	00 A +	-i+.	i	9	39 hours
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a		ce of):	LOCAL	2117			39 hours
	uted	Examiner	Cause (Disease or injury that initiated events	conte	rm	labor	-				
	be executed icien and burial-transit		resulting in death) Last	Due to (or as a	consequenc	ce of):					
8760	ate be executed hysicien and the burial-transi	dical		d							
~ √> «	rtifica ng ph as th	Med	15.55141.5								
Oivision of Vital Records D O Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		th 3 ⊟Ectopic	pregnancy			23d. Date of de	,
ū	ne dea the att	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at ti						Month	Day Year
٥	at the	Phy	9 🗆 Unknown								
U	signed I		Part II. Other significant conditions	contributing to death but	not resulting	g in the underlying	cause given in Pa	art I.		V	to the cause of death?
7	w requir been si should	ted	pulmonar	y nem	orr	nage			1 🗆 Ye	s 2,2 No 3 P	Probably 4 Unknown
Č	e law r has be je 2 sh	Completed by							24a. Was ar	24b. Were a	utopsy findings available completion of cause of
α.	The I	TO.							perform	ned? death?	
<u>;</u>	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				26. PI	ace of Death (C	heck only one	9)	
2	Physic this co	ြို	1 ☐ Yes 2 No	Hospital: 1 Inpatient		Outpatient 3 🗆 🛭	OOA Other: 4	Nursing Home	5 🗌 Reside	nce 6 □Other (Sp.	ecify)
	fler t		27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28t	o. Time of Injury	28c. Injury at Work?	280	I. Describe ho	w injury occurred	
	eath.	cati	2 ☐ Accident investigati			М	1 ☐ Yes 2	No			
Ž	or Attending P after death. I Director: After t d in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, <i>(Specify)</i>	larm, street, lacto	ry, office	28f	Location (Str City or Town	reet and Number or F , State)	Rural Route Number,
	irs at Dell of Indian	ပိ									
	To the Hospitel or Attending Physician: The law requires that the death certific within 24 hours after Carling Physician: The law requires that the death certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Exa	hysician: To the best of aminer: On the basis of e	examination	lge, death occurre and/or investigation	d at the time, date on, in my opinion, o	and place, and death occurred	I due to the ca at the time, da	iuse(s) and manner a ate and place, and du	is stated. e to the cause(s)
	To the Youthin 2 To the Complet	Med	29b. Signature and title of certifier	and manner state	9d.	(1 2	9c. License numb	er	20	ed. Date signed (Mer	th Day Year)
	1 × 5		In I	() the //11	Neme	H0947		OF	23	C/2 2/6	34
	~		Then	- July		′	ノイタン	040		2/47/	(
	. 0		30. Name and address of person who	completed cause of dea	ath (Item 23)		7		R. 11.	and Li	1 11737
ì	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	UKling	quare I	rive	LXLITI	nae, M	TCPIP
	Regist		MAVOA			h	land.	*			

				For State Registrar			State of	Maryla		oartme e <i>rtifica</i>				lental Hy	giene Reg. No.	2004	16748
	v 4 a.	Physicia /Medic Examin	al	1. Decedent's Name (	ELL	TH		ORE nber)	Jo			or Location	of Death	2. Date of De Month	2ay	2007 County of Deal	3. Time of Death 1 1430 PM
		III na	Ť	Upper Ch						) If I los		Bel 2				Harf	
		uneral irector		5. Social Security ! 218–18–5		6. Sex	4 2□F	7. Age (In yrs <b>81</b>	s. ias <i>t birtno</i> a Yrs.	Month	er 1 Year s Days	Hours	Min.	8. Date of Bir 10/4/19	22 <sup>ar)</sup>		thplace (State or Foreign buntry) <b>Yland</b>
	and	*		Usual Residence of	of Decedent 10b. County			10c. C	City, Town or	Location							10d. Inside City Limits
	Maryl	or 28a-f show is notified at	tor	MD	Harfo	ord			White	eford							1 ☐ Yes 2X No
	vith the	or 28g	Funeral Director	10e. Street and Nu							Zip Code				10g. Citiz	en of What Co	puntry?
0	leath w	ns 23a	erai	1304 HE	eaps Roa		. Was Dece	dent Ever in	U.S. 1:		1160 edent of H	dispanic O	rigin? (Spe	ocify Yes or No	- 1	USA 4. Race - Ame	ncan Indian.
143	5-UU36 72 hours after death with the Maryland	item 27 is marked other than "natural", or items 23a or other treumatic event, the Medical Exams are must be	Ď	1 Never Man	ried 2 Marr		Armed For	rces?			2XNo			ocfy Yes or No Rican, etc.)		Black, Whit	
	<b>15-(</b>	"natural", ledical Exp	Be Completed		15. Deceden cify only highe	's Educa st grade o	completed)		16a. De (Gi	edent's Us ve kind of v . DO NOT	sual Occup work done use retire	oation during mo d)	st of worki	ng	16b. Kin	d of Business/	Industry
5	Z1Z1 od within giene.	er then	Somp	Elementary/Second 10	ondary (0-12)		College (1	-4or 5+)		oorer					C	onstru	ction
05	Maryland 21215-0035 and 2 should be filed within 72 hours at 11th and Mental Hydiene.	is marked other than eumatic event, L. M.	To Be (		Thomas	Jones						Be:	rtha	(First, Middle,	Norr	is	
6	Mar nd 2 sh	27 is m treum		19a. Informant's N Ronald I						-				Noute Number		Town, State, 2 21132	Zip Code)
MDDDD 19050	Q = 1	ortant: If item injury or other 8.		20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 ∐Ren	noval from S	20b. State S1	Place of Dis cometery c Late R	position (Nematory of deciding of the deciding	lame of rother play Cemet	ery	5/26/	ate 2004		ation - City or	Town, State
2	Balti permit.	Important: If ite any injury or o once.		21. Signature of F	uneral Service	Liconsee	Low	elu		22. Name H <b>arki</b> r				c.,600 M	ain St	.,Delta,	PA 17314
		sician		23a. Fart1. Enter shock, or her immediate Cause disease or conditi- resulting in death)	ion	complica only one a.	tions that cause on ea	aused the de ach line.	ath. Do not e	inter the m	JON -	ng, such as	s cardiac o	r respiratory a	rest,	OVE	Approximate Interval Between Onset and Death
له		edical ıminer		resulting in deality	,		Due to (	or as a conse	equence of):	DNE	( / ^ ^	( ) A A	Δ				00) 11
04	uted	d ansit	Examiner	Sequentially list co if any, leading to it cause. Enter Und Cause (Disease of that initiated event	lerlying r injury	b	Due to (	or as a conse	equence of):	114	C V V V						
Bulc	1760, Ite be executed	nysician and he burial-transit	ical Exa	resulting in death)	Last	d	Due to (	or as a conse	equence of):								
10		attending phifor use as the	/Med	IF FEMALE:		220	If you out	come of preg	nancu						1		
	P.O. BOX 68 nat the death certifica	by the atten tached for u	Physician/Med	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □ No		1 ☐Live bi	inth 2 ☐ Fe ant at time of	tal death	B□Ectopic i□ Other (		y		.,	2	3d. Date of del Month	rvery Day Year
		signed d be de	ed by P	Part II. Other signi	ificant condition	ons contri	buting to de	math but not re	esulting in the	underlying	Fail	ven in Part	i. <del>/</del>		obacco us Yes 2		the cause of death?
フト	I Kecords, The law requires t	2 5	Completed by	Preun	nonio	<u> </u>	JLEE	DATED	6A1	6RE	news	FOO		24a. Was autop perfo 1 Yes		24b. Were au prior to death?	itopsy findings available completion of cause of
(-	of Vital Physician: T	certific rector,	Be	25. Was case refe examiner?			spital: 🍾 🚗				Cth	oer:		(Check only o			
	DIVISION OF I or Attending Phys after death.	: After this funeral di	tion: To	1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☐ Natural 2 ☐ Accident		g	28a. Date o		28b. Time	of	28c. Injur Wor	4 🗆 14	2	ne 5 Resident			city)
500	DIVISI el or Atter s after dea	I Director	Certification:	3  Suicide 4  Homicide	6 Could determ		28e. Płace buildir	of Injury - At ng, etc. (Spec	home, farm,	street, facto	ory, office		2	28f. Location (S City or Tox		Number or Ru	ıral Route Number,
工	the Hospitel	To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	2   Medical	Examine	r: On the ba	isis of examir	nowledge, de nation and/or	investigation	on, in my o	opinion, de	nd place, a ath occurre	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	Tot	Tol	₹ .	29b. Signature and	d title of certifie	m	re lo	1 6	TRUE	2	29c. Licens	590	135		29d. Date	signed (Monti	n. Day, Year) 2004
		10		30. Name and add	N BY!	who con	50	10 U	PER (		APER	IKE	BE	LAIR	, M	24	014
	3	Sta Registr	-	31. Date filed (Mod MA)		04	32. R	egistrar's Sig	nature	de							

			State of Maryland / Department of Health and I 1- State Amend Item 19b per FH,0831,05/26/04dbb Certificate of Death	Mental Hy	giene 200	4 16749
			Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physici /Medic		Charlotte Koenig	Month	2 ( 2 ) 3	4 9:33 6 M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	h	4c. County of Dea	th
			FRANKLIN SOURCE HUSPITA/ KOSECIA	1e	BALT	more
	Funeral		5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Da	th y, Year) 9. Bi	thplace (State or Foreign ountry)
	Director		212-05-8660 87 Yrs.	02/02/		ryland
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryli Peho	ō	MD Baltimore Baltimore			1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	death with the Maryland ime 23a or 28a-f ehow f.p.ust.ke.p.clift.d.el		8820 Walther Blvd Apt. 206 21234		U.S.A.	
	death me 2:	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No		
۵	or ite		1 Never Married 2 Married 1 Yes 2 X No	(o Hican, etc.)		te, etc.
2	ours	1 by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:		Specify: Wl	nite
15-0036		Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	rking	16b. Kind of Business	/Industry
Z	within 72 ene. than "na	du	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			
Z	filed v Hygie Other t		12 Secretary  17. Father's Name (First, Middle, Last)  18. Mother's Name	ne /First Middle	Drug Cor	ipany
yland		Be		rine Lin		
	should nd Mer marke	은	19a. Informant's Name/Relationship (Type, Print)  19b Mailing Address (Street and Number or Ru			Zin Code)
Ma	C a = 8		William M. Koenig, Jr. (son) 11511 Belair Road -			
	s 1 and if Health Item 27 other ti		20a Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City of	
<u></u>	80=5		1 X Buriai 2 □ Cremation 3 □ Removal from State  1 X Donation 5 □ Other (Specify)  1 X Buriai 2 □ Cremation 3 □ Removal from State  1	7/2004	Timonium	, Maryland
saltimore,	525		21. Stynature of Funeral Service Licensee 22. Name and Address of Facility E			
ñ	permit Depar Impor any Irr		Mothor Roch Chorocic 11750 Belair Road	- Kings	ville, MD 2	21087
	- 3		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician <sup>1</sup>		Immediate Cause (Final	Oulis		Onset and Death
,	/Medical		disease or condition resulting in death)  Due to (onas a consequence of):	110 1 11		
	Examiner		Constitute for any distance			
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):			
	ate be executed hysician and the burial-transit	Examiner	that initiated events c.			
/6O,	e exe		resulting in death) Last Due to (or as a consequence of):			
	ate b hysic the b	lcal				
D O X	death certificate e attending phys id for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		-21-2-1-1-1	a.
X P	attend for us	lan	23b. Was decedent pregnant in the past 12 months?    Compared to the past 12 months   1   1   1   2   Fetal death   3   Ectopic pregnancy   1   1   1   1   1   1   1   1   1		23d. Date of de Month	Day Year
	the de y the s	yslc	1 Q Yes 2 No 9 Unknown 9 Unknown			
7.	that ti ed by detac		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
S	w requires that the de been signed by the a should be detached	d by		1 🗆 🗅	res 2□No 3□P	robabiy 4 Unknown
000	w req beer shou	leted		24a. Was	an 24b. Were a	utopsy tindings available
d)	The law cate has b page 2 s	Comple		autor perfo	prior to death?	completion of cause of
VItal	Iclan: Th certificate ector, pag	e Co	25. Was case referred to medical 26. Place of Dea	1 ☐ Yes ath (Check only o	No 1 □ Yes	2 □ No
	Physician: this certific ral director,	o Bo	examiner?		dence 6 □Other (Spe	ecifu)
Ö	Phy ar this aral c	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occurred	ony)
0	Attending ir death. ector: After by the fune	atlo	Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
DIVISION	Atte	ific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or R	ural Route Number,
5	s efte	Certification:	building, etc. (Specify)	Only or 707	m, olato)	
	To the Hospital or Attending Physician: within 24 hours sites death. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical (	29a. Certifier (Check only   Check , and due to the	cause(s) and manner a	s stated.	
	the H nin 24 the F nplete	ledi	one) and manner stated.			
	Neith Connocation	Σ	29b. Signature and title of certifier  29c. License number		29d. Date signed (Mon	n, Day, rear)
			· Chause paienger & 9 155 0000	00	0/01/0	7
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	30/1	MJ 211	27
	Sta	to.	31. Date tiled (Month, Day, Year) A 32. Registrar's Signature	ICI ITIMOI	e, Madid	7
	Registr		MAY 2 6 2004 And A South			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:45 P<sup>M</sup> Soon Lee May 2004 Chong /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 650 Foreland Garth Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 3 □ F 216-98-1535 72 Director Korea Sep. 25, 1931 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County rai', or itema 23a or 28a-f show Examiner noust be notified at 1 ☐ Yes 2 TXNo Maryland Howard Columbia Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. em 27 is marked other than "natural", or itema 23e or 2 21045 650 Foreland Garth United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Asian If Yes, Give Year or Dates: Specify: δ 3 ☐ Widowed 4 ☐ Divorced er than "nature the Madical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Duk Yong Kim Booja Yang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health : Hee Lee Husband 650 Foreland Garth Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or QDGS. \* 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 5/26/04 Elkridge, Maryland 22. Name and Address of Facility
Gary L. Kaufman Funeral Home At MMP., Inc.
7/250 Washington Blvd. Elkridge, Maryland 21075 21. Signature of Funeral Service Licensee Hucma 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRA ABDOMINAL SIX MONTHS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ρ in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident thin 24 hours after death the Funeral Director: 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Lee		1 - State State Registrar		artment of Health and l rtificate of Death	. •	ene . No. 2004 1675
Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Glen  4a. Facility Name (If not institution, give street and in Bon Secours Hospital)	Lee	4b. City, Town, or Location of Death	2. Date of Death Month May 19.	Day Year 3. Time of Death
Funeral Director		5. Social Security Number 6. Sex 217-68-2355 12 M 2 F	7. Age (In yrs. last birthday) 4 0 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Dey, Y June 7, 1	9. Birthplace (State or Fore Country) 1963 Maryland
the Maryland 28a-f show	Director	10a. State 10b. County  Md •  10e. Street and Number	10c. City, Town or Lo	re		10d. Inside City Lim 1
d 2 should be filed within 72 hours atter death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examerer must be notified at	by Funeral	1215 Gilmore Street  11. Marital Status 12. Was De Armed	2 XNo	10f. Zip Code 21217  Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	US	Citizen of What Country?  A  14. Race - American Indian, Black, White, etc.  Specify: Black
iled within 72 ho lygiene. her than "natur nt, the Medical I	Completed	12th	(Give life.	dent's Usual Occupation kind of work done during most of work DO NDT use retired)  enance Mechani	c Pu	b. Kind of Business/Industry City  Bblic School Sys
S should be filed within and Mental Hygiene. Is marked other than aumetic event, the Mental than an aumetic event, the Mental than the Mental	To Be	17. Father's Name (First, Middle, Last)  Charles Lee  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	18. Mother's Nam Lillian  19. Address (Street and Number or Rui		s) Lee
Pages 1 and 2 nent of Health a nt: If item 27 la iry or other trae		Diane H. Lee ( Wife)  20a. Method of Disposition  Description 3 Democration 3 Democratification 3 Democrat	1215 20b. Place of Dispo	N. Gilmore St.	, Baltim	c. Location - City or Town, State
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	1000	Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)  21. Signatur Funeral Service Licensee	22	Cemetery 05/2  Name and Address of Facility Tr  12 Third St. N	i-State	F/S/Inc.
iste be executed / Medical Examiner   Medical   Italian   Medical	dicai Examiner	Sequentially list conditions, b. Cause. Enter Underlying Cause, Oisease or injury that initiated events ct.	each mie.	ardiovasentar	250	Approximate Interval Between Onset and Death
the death certific y the attending p iched for use as	Physician/Med	in the past 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
es t igne be d	by	Part II. Other significant conditions contributing to a	feath but not resulting in the un	derlying cause given in Part I.		to use contribute to the cause of death?
	e Completed	25. Was case referred to medical			24a, Was an autopsy performed? 1 □ Yes 2 □ 1	
or Attending Physiter death.  Director: After this in by the funeral director	To B	examiner?  1X Yes 2 No  1 No Near No No No No No No No No No No No No No	Inpatient 2 ER/Outpatient of Injury th, Day Year) a of Injury - At home, farm, stre ng, etc. (Specify)	30X DOA Other: 4 \( Nursing Hole Nursi	28d. Describe how in	and Number or Rural Route Number
Hospi 4 hou Funer ely fiil	edical Ce	ZZ modical Examiner. On the	best of my knowledge, death asis of examination and/or invener stated.	occurred at the time, date and place, a stigation, in my opinion, death occurred	and due to the cause and at the time, date a	(s) and manner as stated.  Indiplace, and due to the cause(s)
To the I within 2 To the I complete	2	29b. Signature and the of centifier	N	29c. License number  OCME	1	Date signed (Month, Day, Year)  BY 20, 2004
3		30. Name and address of person who come eted causes of the second of the	e of death (Item 23a) (Type, P	111 Penn Street	t, Baltimo	ore, Maryland 21201

			1 _ State	State of Maryland /	Department of H Certificate of I		ntal Hygien	71114	16752
			Registrar  1. Decedent's Name (First, Middle, Last)		00111110010 01 1		Date of Death		3. Time of Death
	Physicia /Medic		Martha	Lawson		1	Month Da	ey Zoo Y	1559M
>	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or	Location of Death		. County of Deat	h
				is Hospital	Batino			Na	
	Funeral Director		5. Social Security Number 6. Sex	M 200 F	yrs. If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year Epkenben 25	) Co	hplace (State or Foreign untry) M. D
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c City Tou	wn or Location		/		10d. Inside City Limits
	Aaryla f sho	ō	11/2		H-muxe				1 2Yes 2 □ No
	288-	Director	M/D N/A  10e. Street and Number		10f. Zip Code		10g. C	itizen of What Co	untry?
	h with		1248 Braumont	AVE	21239			4.5.4.	
	eme	ner		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	ispanic Origin? (Specif an, Mexican, Puerto Ric	y Yes or No-	14. Race - Ame Black, White	
36	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If item 27 is marked other than "naturel", or iteme 23a or 28a-f show or other freumatic event, it is Maryland Exa. It at invalid the indifferent or other freumatic event, it is Maryland Exa.	by Funeral	1   Never Married 2 Married  3   Widowed 4   Divorced	1 ☐ Yes 2/☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:	,	Specify:	
8	ture!	ed b	15. Decedent's Educ		a. Decedent's Usual Occup	ation	16b. H	(ind of Business/	PCK
215	hin 72 an "na Media	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	during most of working d)			
7	ed wit	Соп	12	0 4	PINATE DUTY 1	NURSING 18. Mother's Name (F	^	URSING	
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, Last)	/	,			n Surname)	
2	2 should be and Mental Is marked o	To	19a. Informant's Name/Relationship (Type	ne Print) 10	9b. Mailing Address (Street	Martha and Number or Bural F		or Town State 7	Zin Code)
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ē,	s 1 ar f Hea item other		20a. Method of Disposition	comet	of Disposition (Name of tery, crematory or other place	Date		ocation - City or	Town, State
altimore,	Pages nent of I ant: If its ary or o		1	emoval from State	316N Cemetery 22. Name and Adres	6/2/	04 BA	HIMORE A	10
att	permit. Pages 1 and 2 Department of Health s Importent: If item 27 li any injury or other tre		21. Signature of Funeral Service License	) <del>0</del>	22. Name and Address	ss of Facility BE A	5 Furaca	1 Home	
<u> </u>	205 2	L (	Patricia K	rest		ARULINE ST		& ND ZI	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death. Do re cause on each line.	o not enter the mode of dyin	ig, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
	Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death)		a: lure				5 years
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	199	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):				billar
	cuted nd transit	Examiner	that initiated events c		bu se				214ears
8760,	cate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or as a consequence	e of):				
387	physic	dical	_ d	l					
9 X C	eath certific attending p I for use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy				23d. Date of deli	ivery
. Box	that the death cer ed by the attendin detached for use	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year
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	es be	by F	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause given	en in Part I.			the cause of death?
orc	w requir been si should	eted	Diabetes me	11.705					
Records,	The faw ate has I page 2 s	Completed by					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Vital		e Co	25. Was case referred to medical			26. Place of Death (0	1 Yes 2 N	1 ☐ Yes	2 No
	Physicien: this certific ral director,	To B	examiner?	lospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Oth	oc.	5 Residence	6 ☐Other (Spec	cify)
0 1	ding Phys .r After this funeral di	L:uc	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b.	. Time of 28c. Injury Work	y at 280	d. Describe how inju	ry occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	50 000		Yes 2 □ No		- 111 - 1	10
Division of	or Attencater death	Certification;	4 Homicide determined	28e. Place of Injury - At home, in building, etc. (Specify)	rarm, street, factory, office	281	Location (Street a City or Town, Stat	e)	iral Houte Number,
	To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	sician: To the best of my knowledgener: On the basis of examination a	ge, death occurred at the tin	me, date and place, and	I due to the cause(s	and manner as	stated.
	the Hin 24 the Fu	Medical	one)	and manner stated.					
	To Your	2	29b. Signature and title of certifier	11	29c. Licens		29d. Da	ate signed (Month	n, ∪ay, Year)
7	~		30. Name and address of person who co	(aus, m)	RES.	-000	ma-	23 5	7004
	, 0		0	600 North and Re	(Type, Print)  Street, Marby	ca B-1810 F	altimore n	reviewd	7846
	Sta		31. Date filed (Month, Day, Year)	, 32. Registrar's Signature	19 Anni		-11 7 21 101 6 1 1.	1 1611-61	
	Registr	ar	MAY 2 6 200	14	~ jajours.	2"			

State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 May 23, Louise Johanna List 12:50pM /Medical **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Rossville Baltimore 8. Date of Birth (Month, Day, Yea May 4, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 M 200 220-32-3328 93 Director 7911 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Examinational be nutified at Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Middle River 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10 Hammock Trail 21220 238 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ont: If item 27 Is marked other than "netural", or Items 23 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Hoer Elizabeth ပ Friedrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tree once. John List (Son) 10 Hammock Trail, Baltimore, Maryland, 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn May 26,2004 Woodlawn, Maryland 21. Signature of Funeral Service Liggnsee 22. Name and Address of Facility Bruzdziński Funeral Home, P.A 1407 Old Eastern Avenue, Essex, Maryland, 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) et and Death **Physician** dden 201010C /Medical Due to (or as a consequence of) Examiner mestens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a do nsequence of Examiner SCVI. The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9□ Unknown 9 Unknown ρλ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Be Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2□ No 1 🗌 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certification: To 1 ☐ Yes 2 No 1 Inpatient Cther: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation M 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertifie 0 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed care of death (Item 23a) (Type, Print ahnamo 9512 HARFARD RD, STE 4 Bulto, MD. 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 6 2004 Registrar

			1 - For State Registrar	te of Maryland / Dep Ce	partment of He ertificate of D		lental Hygie	711114	16754
	Dhusisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		Charles Willia	am Lamm				2004	8:30 A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give street a		4b. City, Town, or I			4c. County of Death	
			Frederick Memorial  5. Social Security Number 6. Sex		Freder:	LCK If Under 24 Hrs.		Frederi	
	Funeral. Director		218-24-9510 1DXM 20	7. Age (In yrs. last birthda) 75 Yrs.	Months Days	Hours Min.	May 9, 10	9. Birth Mary	place (State or Foreign Intry) Land
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Mary f sho	ō	Maryland Frederick	Frederi	ck				Yas 2 No
	be filed within 72 hours after death with the Maryland that hygiene.  do other than "naturel", or items 23a or 28e-f show event, the Medical Examinar must be notified at	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?
	th wit	alD	1607 Jennings Cou	t	21702	2	Ū	J.S.A.	
	r dea	Funeral	Arm	s Decedent Ever in U.S. 13 ed Forces?	. Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe . Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married ☐ ITY 3 ☐ Widowed 4 ☐ Divorced Year	Yes 2 □ No es, Give 1948-1951 or Dates:	1 ☐ Yes 2/7/No	Specify:		Specify.Whit	
8	hour fure	ed b	15. Decedent's Education		edent's Usual Occupat	ion	106		
15	n na	Completed	(Specify only highest grade compi	eted) (Giv	e kind of work done du DO NOT use retired)	iring most of worki	ng	. Kind of Business/Ir	naustry
212	filed with Hygiene. ther than	mo;	Elementary/Secondary (0-12) Coll	ege (1-4or 5+) Self	Employed Bric	k Mason		Construc	tion
힏	al Hy d other	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid		
Maryland 21215-0036		2	Alonza E. Lamm			Minn	ie Barret	t	
Jar	OI 10 - 0		19a. Informant's Name/Relationship (Type, Print		ling Address (Street an				
e,	of Health item 27 other tr		Mrs. Frances M. Lamm  20a. Mathod of Disposition		Jennings				
Jo	m 0 -		1 Burial 2 □ Cremation 3 □ Removal	from State St. Pauls	position (Name of ematory or other place)	Mes. 27	, 2004 Po	Location - City or T	
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Septice Licensee		,				
Ba	permit. Departr Importe any inje		* Richar E Dra		Keeney and Address 106 East C			al Home ick, MD 2	1701
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not ele on each line.	nter the mode of dying,	such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Prysician		Immediate Cause (Final disease or condition resulting in death)	PNEUMONIA					Onset and Death
	/Medical Examiner		Di	ue to (or as a consequence of):	_				
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. First Interving Cause (Disease or injury that initiated events						
oʻ	exec an an		regulting in death) I and	ue to (or as a consequence of):					
8760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	dicai	d						
9	artifica ing ph e as ti	Med	IF FEMALE:						
Box	eath certific attending p for use as	ian/l	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy			23d. Date of deliver	Day Year
	t the de by the a lached f	Physician/Me	1 □ Yes 2 □ No 4 □	Pregnant at time of death 5 Unknown	Other (specify)			Widniti	Day Fear
P.O.	that the ed by detac		Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given	in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
Records,	The law requires that te has been signed b page 2 should be deta	d by	Chronic Obstruct		eary Dis		-1		pably 4 Unknown
000	s been si should	olete			/		24a. Was an	24b. Were auto	psy findings available
æ	The lavate has	Completed					autopsy performed	prior to co death?	mpletion of cause of
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	ys diib	To B	examiner?  1 Yes 2 No Hospital:	npatient 2 ER/Outpatie			ne 5 Residence	6 ☐Other (Specif	iy)
0	ng Pi		27. Manner of Death 1 Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury a Work?	it 2	8d. Describe how in		
sio	Attending r death. sctor: After y the fune	cati	2 Accident investigation			s 2 No			
=	l or At after of Direct I in by	Certification:	determined 289.	Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	2	8f. Location (Street City or Town, Sta	and Number or Rura ite)	l Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Examiner: On	o the best of my knowledge, dea	th occurred at the time,	, date and place, a	nd due to the cause	(s) and manner as s	tated.
	the H in 24 the F plete	<b>l</b> edical	and	the basis of examination and/or in manner stated.					
	Viit To Corr	Σ	29b. Signature and title of certifier	4.0	29c. License n		1	ate signed (Month,	· · · · · · · · · · · · · · · · · · ·
7			1//			57796	M	AY 25	, 2004
	8		30. N e and address of person who completed Lalit Verma, M.D., 4	cause of death (Item 23a) (Type 00 West Seventh	Street, F	rederick	, Maryland	1 21701	
7	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		· · · · · · · · · · · · · · · · · · ·			
4	Registr	ar	MAY 2 6 2004	and It Anen	E P				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 16/1M Margaret Ρ. 5 Labroi 04 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Alice Manor Nursing Home Baltimore 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) 12-31-1914 Warrenton, NC 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 21 🔀 F 89 Director 219-16-9346 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow traumatic event, the Medical Examiner quet be notified at 1 ☐ Yes 2 ▼ No Director N.C. Warren Co. Warrenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a Warrenton, N.C Funeral P.O. Box 304. death 27589 USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" eny injury or other treumatic energy in the page. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes Yolo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) System Elementary SchoolTeacher Chicago School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Lee Parham Clemon Townes Parham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Parham Brothers 3600 Sequoia Ave, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Cooks Chapel Cem. 5-27-04 Warrenton, N.C. Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21. Signature of Funeral Service Licensee Lloyd M. Estep

Estep Brother's Funeral S

1300 Eutaw Place, Baltimo

23a. Part. Enter the disease, or complication's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner neumous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐ Yes 2☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 TO Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1L Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FURNACE BRANCH RD, GLEN BURNE, YED 31. Date filed (Month, Day, Year) State Registrar

				nt in Black Indelible ink. Ensure A	-	-	
				laryland / Department of Health and N	nental Hyg	giene 2001	. 16756
			1 - Stata Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Dea	iog. 110.	3. Time of Death
	Physici		Vinnie L. Myrie		Month	Day Year	. 11.6.0.
	/Medic Examin		4a. Facility Name (If not institution, give street and number		may	4c. County of Dea	·
	LAGITIII	CI	Sinai Hospital of Be	altimore Baltimore	2ity	N/A	
	Funeral	П	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day	9. Bir	thplace (State or Foreign ountry)
	Director		111-30-9285 1 M 2 F Usual Residence of Decedent	66 Yrs. World's Days Hoors Willing			.Carolina
	/land		10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
	Many Be-1 sh	tor	Maryland N/A	Baltimore			1 Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What C	ountry?
	ath w		3810 Fallstaff Road #			USA 14. Race - Am	
	er de itams	Funerai	11. Marital Status  12. Was Decedent Armed Forces	? If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian, te, etc.
36	al', or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☑ If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes ¾ No Specify:		Specify:	Black
Ö	within 72 hours after death with the Maryland ene. Then "naturel", or itams 23a or 28e-1 show its Modical Exeminer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work		16b. Kind of Business	
2	ithin 7	npie	Elementary/Secondary (0-12) College (1-4or	life. DO NOT use retired)		lead Star	t Program
7	filed w Hygier Sther th		12th grade 17. Father's Name (First, Middle, Last)	Dietician			
anc	d be finital Head of	Be	Elmore Gardner	18. Mother's Name			
Ž	2 should be filed within and Mental Hygiene. Is marked other then eumetic event, Ire Me	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	Harriso	n. City or Town. State.	Zin Code)
Baltimore, Maryland 21215-0036	D = N =		Carlton Myrie, Jr.	3810 Fallstaff Road	#1A Ba	ltimore	Maryland
e,	permit. Pages 1 and Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition	20b. Place of Disposition (Name of	Date	20c. Location - City or	
Ĕ	Pages ment of ent: If it ury or o		*4 □ Donation 5 □ Other (Specify)	Mt. Zion Cemetery 5/2	24/04 B	altimore	, Maryland
3alt	Departi Departi Import eny inj once.		21. Signature of Funeral Service Liceny ee	22. Name and Address of Facility Cha	tman-H	arris Fu	neral Home
	₫ 🗆 🙃 Ol	11	Thrung Flur	J240 Reisterstow	u ka B	altimore	Md 21215
	-		shock or heart failure. List only one cause on each	d the death. Do not enter the mode of dying, such as cardiac line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ite Myscordial Infa	urction	ა	1 day
	Examiner			epsis			2 clays
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				4-
	ecuter and trans	Examiner	that initiated events c.	esity			unknown
60,	be executed sician and burial-transit		Due 10 (01 a.	s a consequency of: I monory Edena			unknow
687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d	monary carema			
Box	n certii anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome			23d. Date of de	livery
œ.	death	icia	in the past 12 months?	2 ☐ Fetal death 3 ☐ Ectopic pregnancy tt time of death 5 ☐ Other (specify)		Month	Day Year
P.O.	res that the de igned by the a be detached t	Phys	9 ☐ Unknown 9 ☐ Unknown				
Š,	res th	by	Part II. Other significant conditions contributing to death			bacco use contribute to es 2□No 3□P	o the cause of death?
0.00	w require been sign should b	etec	Proper Resident, Dian	etes mellitus, Acute emodialysis, Congestive	-		
Rec	has be a s	Completed by	Kenal tailure on H	emodialy sis, congestive	24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
Division of Vital Records,	Physicien: The la r this certificate has	e Co	Heart Failure 25. Was case referred to medical	26. Place of Deat	1 ☐ Yes	2 No 1 Yes	212 No
>	ysicie is cert direct	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpati				ecify)
0	ng Ph fter th neral	L :uc	27. Manner of Death 1 Natural 5 Pending (Month, Da	ury 28b. Time of 28c. Injury at Work?		ow injury occurred	,
Siol	endir eath. or: Al	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Ž	ol or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	determined 288. Place of In	jury - At home, farm, street, factory, office tc. (Specify)	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
	Hospitel 4 hours a Funeral I tely filled		29a. Certifier 1 Cartifying Physician: To the best	of my knowledge, death occurred at the time, date and place,	and due to the c	auso(s) and manner as	etated
	To the Hospitel or Attending Physicien: within 42 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director; it	edicai	(Check only 2 Madical Examiner: On the basis one) and manners	of examination and/or investigation, in my opinion, death occurr	red at the time, d	ate and place, and due	to the cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mont	h, Day, Year)
	L		· and	- RES-000	·	MAY 18,	2004
	S		30. Name and address of person who completed cause of			0	
	Sta	té	CRYSTAL C. WATKIN  31. Date filed (Month, Day, Year)  32. Regist	rar's Signature	- UF 131	MITIMOR	E
	Registr		MAY 2 6 2004 Sens	ve & Sparks			
			ATTICL IN U LUUT	- Joseph			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary L. Martino May 20, 8:12P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 02-27-1932 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Days Hours Yrs. Director 577-42-8927 72 Washington, DC Usual Residence of Decedent with the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "netural", or Items 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3949 Ramsey Drive 21037 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "netural", or Item any injury or other traumatic event, the Medical Evented-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: ě 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hubert Rogers Rose Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip A. Martino/ Husband 3949 Ramsey Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 5-24-04 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se Shock Physician 30 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transif law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ discose 1 Yes 2 No 3 Probably 4 Nnknown this certificate has been siral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2. No 2 No 1 ☐ Yes 1 Yes To the Hospitel or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours affer deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 124804 30. Name and address of person who completed cause of death (Item 23a) (Type Annopolis Md 21401 che, 7 e1 EISON 31. Date filed (Month, Day, Year) MAY 2 6 2004 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Miller, Helen

		State of Ma  State of Ma  State of Ma  For State Registrar AMEND ITEM #5 PERFH (  1. Decedent's Name (First, Middle, Last)	ryland / Depa	artment of H	ealth and M	lental Hygio	ene 1. No. 2004	16759
Physicia /Medic	al	Etta Jane Mitche  4a. Facility Name (If not institution, give street and number)	ell	4b. City, Town, or	Location of Death	May 2	Day Year 2004  4c. County of Deeth	10:15P <sup>M</sup>
Examin Funeral Director		Upper Chesapeake Medica	Center o (In yrs. last birthday) 78 Yrs.	Bel Air If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, April 24	Harford  (ear) (1926 Mary	olace (State or Foreign ntry) y Land
Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Harford	10c. City, Town or Lo	ocation			ľ	10d. tnside City Limits 1 ☐ Yes 2 🛣No
with the	Direc	10e. Street and Number 1143 Taylor Road		10f. Zip Code 21154			g. Citizen of What Cou USA	ntry?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentat Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f ehow other traumatic event, the Medical Examinat must be nyillised at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Amed Forces?  1 Yes 2 Married  1 Yes 2 Mr Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amen Black, White, Specify: Whi	etc.
vithin 72 hounde.	Completed !	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	dent's Usual Occup a kind of work done of DO NOT use retired memaker	during most of work		6b. Kind of Business/Ir	dustry
should be filed wind Mental Hygier is merked other than amatic event, the	To Be Col	12 17. Father's Name (First, Middle, Last) Ulysus Lawrence Wall.		menaker	18. Mother's Nam Verda	e (First, Middle, M u/k		
s 1 and 2 shou if Health and M item 27 is mer other traumat		19a. Informant's Name/Relationship (Type, Print)  Gale I. Mitchell (husband) 20a. Method of Disposition	114	3 Taylor	Road, St	reet, Ma	City or Town, State, $Z_i$ $ryland$ $21$ Oc. Location - City or T	154
t. Page ntment o rtant: M njury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Bel Air	Mem. Gard  Name and Addre	ens May	-	Bel Air,	
Pnysician		23a. Part1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list mmediate Cause (Final disease or condition	the death. Do not en	CCOMAS FU 317 Cokes ater the mode of dyin	ng, such as cardiac	or respiratory arre		Approximate Interval Between Onset and Death
/Medical Examiner  /sician and e purial-transit	sal Examiner	Gaque relativists conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):  a consequence of):  a consequence of):		/			
death certifical e attending phy id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopMs? 1 □ Yes 2 MNo 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc	у		23d. Date of delin Month	rery Day Year
juires that t n signed by uld be deta	þ	Part II. Other significant conditions contributing to death to	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2 No 3 Pro	the cause of death? bably 4 DUnknown
The law requires that the also has been signed by the page 2 should be detache	Completed					24a. Was ar autops perform 1 Yes 2	prior to o	opsy findings available ompletion of cause of 2 No
Attending Physician: The ir death. ector: After this certificate his by the funeral director, page	atlon: To Be	27. Mann   eath   28a. Date of Inj.   1	ent 2 ER/Outpatie ury y Year) 28b. Time Injury	of 28c. Inju	ner: 4 ☐ Nursing H	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 Other (Spec	(fy)
i i i i e	Il Certification:	4 Homicide building, e	jury - At home, farm, s tc. (Specify) of my knowledge, dea	ath occurred at the ti	me, date and place	City or Town	use(s) and manner as	stated.
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only one)  2 Medical Examiner: On the basis of and manner services.  29b. Signature and title of services.	of examination and/or i	29c. Licen	opinion, death occu	rred at the time, da	ate and place, and due of the signed (Month)	to the cause(s)
5		30. Name and address of person who completed cause of	death (Item 23a) (Type	Srint) 21/	2 BE	LAIR	ROAD	WD 2-164
St Regist	tate	31. Date filed (Month, Day, Year)  32. Regist	rar's Signature	1	· ] · · · · · · · · · · · · · · · · · ·			

ORIGINAL

			1 - State of Marylar Registrar	nd / Depa <i>Cer</i>	rtment of H	lealth and M Death		giene 0	L	16760
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ith	. 67	3. Time of Death
	Physici /Medic		Galen Edwin Moomaw				Month May	24, 200	rear 4	10:20 A M
	Examin		4a. Facility Name (If not institution, give street and number)		• • • • • • • • • • • • • • • • • • • •	Location of Death		4c. County of		
			Upper Chesapeake Medical Campu		Bel A	Ut If Under 24 Hrs.	0.0	Harf		
	Funeral Director		5. Social Security Number 228-12-1154 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept.	15,1923	, Coun	ace (State or Foreign try), GLNLA
-	and W		Usual Residence of Decedent           10a. State         10b. County         10c. Ci	ity, Town or Lo	ation	-			11	Od. Inside City Limits
	after death with the Manylan or Itams 23a or 28a-f show minat must be mutified at	ō	Maryland Harford		Јорра	,				1 □Yes 2√ No
	r 28a	rec	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	nat Coun	try?
	th with	al D	2516 Lincrest Road			21085		u.s.	A.	
7	ams	Iner	11. Marital Status  12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black,	Americ White,	
36 75	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 🛣 Married 1 🛣 Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		□Yes 2X No	Specify:		Specify:	Wh	ite
7 8	2 hour	ed t	15. Decedent's Education	16a. Deced	ent's Usual Occup	ation		16b. Kind of Bus	iness/Inc	lustry
10	hin 72 an *ng Media	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of OO NOT use retired	during most of work d)	1			
213	THE CO. IN CO.	Com	12th Grade	In	spector			Western		ctric
land	tal Hygie d other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			)	
≥  aryla	D 2 2 0	ို	Edward F. Moomaw	405 14-15-	- Add (C44	Sally	<u></u>	pner	4-4- Ti-	0-4-1
Mai	d d 2	1	19a. Informant's Name/Relationship (Type, Print)  Dr. Keith Moomaw (Son)			and Number or Rur Ct., Joppo		r, City or Town, S 11085	гатө, ∠ір	Code)
> e	s 1 and f Health itam 27 other tr		20a Method of Disposition 20b.	Place of Dispos	sition (Name of			20c. Location - C	ity or To	wn, State
5/3	permit. Pages Department of mportant: If it any Injury or o		1 Burial 2 Cremation 3 Alternoval from State		natory or other place on Cemete		/2004 N	ut. Jack	son.	Virginia
S altin	permit. Pages Department of Important: If i any Injury or o		21. Signature of Funeral Service Licensee			ss of Facility Sch	et and the second			
Ä	Depar Impo		Mall	(	9705 Bela	iir Rd., I	Baltimor	Le, MD 21	236	
			23a. Part1. Enter the disease, or complications that caused the deschock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyin	ig, such a diac	or respiratory are	rest,		Approximate Interval Between
	Prysician		Immediate Cause (Final disease or condition	lespi	rator	Laile	ure		1	Onset and Death
~	/Medical Examiner		resulting in death)  Due to (or as a conse	/ /		1	/	e		<i>*</i> 0
7/2		<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consecutive conditions).		ronav-	of by	1000	5	110	1 years
334	uted Insit	Examiner	f any, leading to immediate cause. Enter Underlying Causa Ca	<b></b>	- 2					
-	cate be executed obysician and the burial-transit	Exa	resulting in death) Last  Due to (or as a consection)	quence of):						
0 4	cate be ohysicia the bur	dical	d							
A 0	artifica ing ph e as th	Med	IF FEMALE:	<del></del>						
Sox Sox	leath certific attending p	lan/	23b. Was decedent pregnant    23c. If yes, outcome or pregnant   1 □ Live birth   2 □ Fet	al death 3	Ectopic pregnancy	,		23d. Date Mont		ry Day Year
0.	requires that the death certificen signed by the attending I hould be detached for use as	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5∟	Other (specify)					-
7 9	that the the the the the the the the the th	y Ph	Part H. Other significant conditions contributing to death but not re-	sulting in the ur	derlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to th	e cause of death?
g sp	w requires been signs should be	ed by	2006 Simus Synd	vone			1 🗆 Y	es 2 No 3	Prob	ably 4 Unknown
- Cor		Completed	Percelongenter Des	22188			24a. Was a		ere autop	osy findings available inpletion of cause of
Ch "	0 4 0	E O					perfor	med? de	ath?	
ital	iclan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only or	ne)		
3 5	S D	ို	1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien		4 Li Nursing He		ence 6 Other	-	)
_	ding Ph J. After th funeral	ion	27. Manner of Death   Natural   5   Pending   2   Accident   investigation	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe n	ow injury occurred	3	
7 Ma. Division	Attending r death.	ertification;	3 Suicide 6 Could not be 28e. Place of Injury - At h	nome, farm, str			28f. Location (S	treet and Number	or Rura	l Route Number,
Div	after after Dira	erti	4 Homicide determined building, etc. (Speci	ify)			City or Tow	n, State)		
$\mathcal{N}_{\mathcal{OOM}}$	To the Hospital or Attention 24 hours after death To the Funeral Director: completely filled in by the	dical C	29a. Certifier 1 Certifying Physician: To the best of my kn (Check only one) 4 Madical Examiner: On the basis of examinand manner stated.	lowledge, death ation and/or inv	occurred at the tin	ne, date and place, pinion, death occur	and due to the cred at the time, c	cause(s) and mani date and place, an	ner as st	ated. the cause(s)
	omple	Med	29b. Signature and title of ceasilier		29c. Licens	e number	2	29d. Date signed	(Month, I	Day, Year)
	-/		THE A TO FINE	18	H39	550	1	11/44 2	5	2004
i	241		30 Name and address of person who completed cause of death (the	m 23a) (Type,	Print)	5/	16"	· · · · · · · · · · · · · · · · · · ·		
_\	10		VETTER LOVIEST 1308 Bu	giuss (	on Wa	y toge	rund	1110 0	10	40
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Sign	nature Li	1	1:/				
	Hegisti		MAY 2 6 2004	13	process	1.				

			For State Registrar	State of	Maryland / Dep Ce	ertificate of		R	eg. Ne2 0 0 L	
	Physici		1. Decedent's Name (First, Middle, Last)  Norma		Mai	donado		2. Date of Dear	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, give s University of Marylo		er)	Baltim	r Location of Death Ove, MD		4c. County of De	_
	Funeral Director		5. Social Security Number  519-38-4759  Usual Residence of Decedent	7.	Age (In yrs. last birthday  65  Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 18	Year) 9. E	Sinthplace (State or Foreign Country) Idaho
	72 hours after death with the Maryland naturel', or Items 23e or 28a-1 show deal Examiner must be notified at	Director	10a. State 10b. County  Maryland Anne Aru  10e. Street and Number	ındle	10c. City, Town or I	GLEN BWT	nie	1	Og. Citizen of What	10d. Inside City Limits 1 Yes 2 No
	72 hours after death with the Marylan naturel', or Items 23e or 28e-f show dical Examiner must be millied at	Funeral Dlr	102 N. Crain Highw	12. Was Decede Armed Force	es?	. Was Decedent of H	21061 lispanic Origin? (S an, Mexican, Puert		u.s	. A. merican Indian,
5-0036	2 hours afte laturel', or l	b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Edur (Specify only highest grade		es:	edent's Usual Occup	Specify:	ting	Specify:	White ss/Industry
Maryland 21215-0036	l within iene.	Completed	Elementary/Secondary (0-12) 12th Grade  17. Father's Name (First, Middle, Last)	College (1-4	or 5+)	Truck Dr	iver	ne (First, Middle,	Owne	r
rylanc	d be ental	To Be	Emil Maldonado  19a. Informant's Name/Relationship (Ty,	ne Print)	19b. Ma.	ling Address (Street	ELF	leda Waf		a. Zip Code)
	s 1 and 2 shoul f Health and Mi item 27 Is mari other traumati		Edward Jaworski (S		5501	Alban Ai	enue, Ba	ltimore,	Maryland	21214
Baltimore,	t. Page rtment o rtent: If njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from St	Bayview	osition (Name of ematory or other place  Crematory  Chematory	5/25	/2004	Baltimore,	Maryland
Ba	permi Depa Impo any ii		21. Sonatore of Funeral Serve Lice 2.  23a. Partt. Enter the disease, or compli	THE	1 /	3331 Breh	ıms Lane,	Baltimo	Funeral H re, Maryl	and 21213 Approximate
	Pnysician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Abdo	minal sep		ig, such as cardiac	or respiratory arr	esi,	Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	. /Sche	as a consequence of):  emic bow as a consequence of):					months
,00	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	nal woun as a consequence of): navy arte	d inted	hon			months
68760,	rtificate b ng physic as the b	Medical	IF FEMALE:	LOVOI	havy arte	ny bypa	لك			mid(in)
.O. Box	it the death certifica by the attending ph tached for use as It	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ▼ No 9 □ Unknown	1 ☐ Live birt	nt at time of death 5	□Ectopic pregnanc □ Other (specify) _	<i>t</i>		23d. Date of Month	delivery Day Year
Records, P.	uires tha signed d be de	by	Part II. Other significant conditions cor	ntributing to dea	th but not resulting in the	underlying cause giv	ren in Part I.	23e. Did to	A	to the cause of death?  Probably 4Unknown
al Reco	The ate h page	Completed						24a. Was a autops perform	sy prior	autopsy findings available o completion of cause of ? es 2 \sum No
of Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	fospital: 1 🖼 np	patient 2 ER/Outpati	ent 3 DOA	ner: 4 Nursing H	ath (Check only or Iome 5 ☐ Resid	ne) ence 6 □Other (S	oecify)
Division o	ending eath. or: After the fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Day Year) Injury	M 1	yat rk? Yes 2 □ No		ow injury occurred	
Divi	Pite in Dir	Certifi	4 Homicide determined	building	f Injury - At home, farm, s g, etc. (Specify)		441814141414	City or Tow	n, State)	Rural Route Number,
V	To the Hospitel within 24 hours and the Funerel I completely filled	Medical	29a. Certifier (Check only one)  1  Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the b ner: On the bas and manne	est of my knowledge, de is of examination and/or ir stated.	investigation, in my o	pinion, death occu	irred at the time, d	late and place, and o	lue to the cause(s)
)	with To t	Σ	29b. Signature and title of certifier  Ariska Lisa	Tax	-	29c. Licens	14551	2	29d. Date signed (Mo May 2	2, 200 Y
1	1		30. Name and address of person who co		of death (Item 23a) (Typ	e, Print) Street,	Baltimon	re, MD	21201	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 6 20	32. Reg	gistrar's Signature	1 Sport	5	•		onth, Day, Year) 2, 206 Y

			Please I  - For State Registrar	State of Maryland	Depa		leaith and M	lental Hygi	_	04 16762
< /M	ysicia ledica		Decedent's Name (First, Middle, Last)     COVING	6.Morgan				2. Date of Death Month May 22,	2004	Yeer 3. Time of Death 10:00 A M
Exa	amine	r	4a. Facility Name (If not institution, give s 4304 Belle Grove	e Road,		Baltim	Location of Death		Anne A	rundel
Fund Direc			5. Social Security Number 6. Sex 220-22-9892 1	M 2 TF 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov 15,	1927	9. Birthplace (State or Foreign Country) Maryland
e Maryland Be-f show	in pagino	Director	10a. State 10b. County Maryland Anne Aru	ndel Balt	imor					10d. Inside City Limits 1 ☐ Yes 2 ∑ No
th with the	ST De US	a Dire	10e. Street and Number 4304 Belle Gr	ove Road		10f. Zip Code	2122	5	g. Citizen of Wh	nat Country? USA
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28e-1 show	and the same and t	by Funeral	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces?       Yes 2 No         Yes 2 No         Yes Give Year or Dates:	l li	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, White, etc. White
vithin 72 ho	I've Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done of DO NOT use retired Homemaker	during most of worki f)	ng	6b. Kind of Busi	ness/Industry Ee & Mother
Baltimore, Maryland 21215-0036  sernit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene.  mportant: If item 27 is marked other then "natural; or	atic event,	lo De C	17. Father's Name (First, Middle, Last)	Leon Wright			18. Mother's Name Cora V	arfield		
Mar and 2 sho alth and 27 le m	r treum	ĺ	19a. Informant's Name/Relationship (Type Charles J. Morgan	oe, <i>Print)</i> , Jr. (Husband)	9b. Mailin 43(	g Address <i>(Street a</i> 04 Belle	and Number or Aura Grove Rd.	ARoute Number, , Baltin	City or Town, St nore, Mc	ate, Zip Code) 1. 21225
imore, Pages 1 ament of He	ury or other		20a. Method of Disposition 1	emoval from State Ceda	r Hi	sition (Name of patory or other place 11 Cemete	ery 5/26			ity or Town, State e, Maryland
Departitude	any in		21. Signature of Fundan Service License	• Kevin E Ecke	Mo	Name and Address Cully-Po 37 E. Pat	s of Facility Lyniak Fu apsco Ave	neral Ho	me, P.A	id. 21225-1856
Physici		i	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	lung	ane ton o	er the mode of dyin-				Approximate Interval Between Onset and Death
/Medio Examir	ner			Due to (or as a consequence						
/60, e be executed sician and	ימו-נומוואון	Cyalling	Sequentially list conditions, [any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c.	Due to (or as a consequence						
68/60, ificate be ex g physician		2	d.							
death cert e attending	and to total		IF FEMALE: 23b. Was decedent pregnant in the past 12 morphs? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month	,
Hecords, P.O. The law requires that the lie has been signed by the layer?		בר ל	Part II. Other significant conditions conf	ributing to death but not resulting	in the un	derlying cause give	on in Part I.	23e. Did toba	_	ute to the cause of death?
	2000	in a second						24a. Was an autopsy performe	prio	re autopsy findings available or to completion of cause of th?  Yes 200 No
Of VITAL Physician: The This certificate		ונ	25. Was case referred to medical examiner?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)	ospital: 1 ☐ Inpatient 2 ☐ ER/0	outpatient	3□ DOA Othe	26. Place of Death	(Check only one)	e 6 ∏Other	(Specific)
ding After			27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Time of Injury	28c. Injury Work		8d. Describe how		
DIVISION TENDOR ATTENDED TO STATE OF COMPANY AND TO STATE OF COMPANY THE COMPA	Cortifi		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	tarm, stre	et, factory, office	2	8f. Location (Stre City or Town,	et and Number ( State)	or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Discussion or modeled in	Modical and		29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examination (Check only one)	cian: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death and/or inve	occurred at the timestigation, in my op	e, date and place, a linion, death occurre	nd due to the cau d at the time, date	se(s) and manne and place, and	er as stated. if due to the cause(s)
To the Vithin To the	(h)		29b. Signature and title of certifier  Multiple Signature and title of certifier	Muxim	2	29c. License	number 44864	290	Date signed (A	Month, Day, Year)
		ij.	30. Name and address of person who con	npleted cause of death (Item 23a	) (Type P	rint)	Paraden	a MD	21122	
Reg	State jistrar	_	31. Date filed ( 444 ) ( 2. 18 ar) 2004	32 Registrar's Signature	6	Spark	/			

			State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep	artment of Health and N rtificate of Death		ene2004	16763
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		Henrique C. Melo Neto		May 22,	Day Year 2004	7:25 рм
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			Casey House	Rockville		Montgome	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1214-61-9777 7. Age (In yrs. last birthday, 57 7. Age (In yrs. last birthday, 157 7. Age (In	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth Feb. 8,	1947 Braz	place (State or Foreign intry) :11
_	pun *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	Aaryla eho	5		ersburg			1 Yes 2 No
	28a-	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	
	3e or		19027 Mills Choice Road	20886		United S	tates
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
2	or Ite	F	1 ☐ Never Married 2 📉 Married 1 ☐ Yes 2 📉 No	1 X Yes 2 No Specify: Hi		Black, White	
3	urel',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				
2	"net	lete	(Specify only highest grade completed) (Give	dent's Usual Occupation e kind of work done during most of worl DO NOT use retired)	king	6b. Kind of Business/l	ndustry
7	withi iene. rthen	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	chanical Engineer		Engineeri	.ng
2	e filec Il Hyg other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	
a	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28a-f ehow or other treumatic event, the Medical Exami	ToE	Jose T. Neto	Amalia	Neto		
8	2 should and Men is marke reumatic			ing Address (Street and Number or Rui			·
ב נ	f and fealth m 27 ther to		Ermelinda Melo/Wife 1902  20a. Method of Disposition 20b. Place of Disp	7 Mills Choice Ros		ersburg, M	
5	ages nt of h t: If ite		1 Burial 2 NCremation 3 Removal from State	e Crematory at LP		·	
	permit. Pages 1 and 2: Department of Health at Importent: If item 27 is eny injury or other tret. 000.00.			Sname and Address of Facility Fun 1040 Rockville Pil		Baltimor Cremation	
<u> </u>	90E 29	-	Mani J. Helland	1040 Rockville Pil	ke Rockvi	11e, MD 2	
			—25a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	iter the mode of dying, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  A Metastatic Cance Due to (or as a consequence of):	r			months
	Examiner		Colon Concon				vears
	ב ס	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				<u> </u>
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c				
0000	icate be executed physician and s the burial-transit		Sec to for as a consequence con.				
000	ficate p phys	edical	d				
5	death certific attending pl	In/M	IF FEMALE: 23b. Was decedent pregnant 1	□Ectopic pregnancy		23d. Date of deliv	•
ם ذ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me		Other (specify)		Month	Day Year
Ĺ	that the sed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
S C	quires n sign	d by			1 □ Yes	2X No 3 Pro	bably 4 Unknown
2	s bee	Completed			24a. Was an	24b. Were aut	opsy findings available
ב	The la	lwo			autopsy performe 1 Yes 2	ed? death?  No 1 □ Yes	ompletion of cause of 2□ No
Ö	sien: artifica ctor. p	Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)		
5	Physicien: r this certifica ral director, i	2	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ome 5 Residen		₩ Hospice
2 2	ling P	lon:	27. Manner of Death 1 ▼Natural 5 Pending 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	Home
2	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm, si		28f. Location (Stre	et and Number or Rui	al Route Number,
<u> </u>	al or A s after il Dire	Certification;	4 ☐ Homicide determined building, etc. '(Specify)	,	City or Town,	State)	
	To the Hospital or Attending Physicien: The law requires that the death cerwithin 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical (	29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	ro the vithin to the comple	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	Day, Year)
	~		· Effete no	DO 9470	ı	May 23, 20	04
	18		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. E.P. Libre 10400 Connecticut	Print) Avenue, Kensingto	on, MD 2	0805	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	books -			
			MAY 2 6 2004	7			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No. 2004	16761
ı	Physician	Decedent's Neme (First, Middle, Last)		2. Dete of Death Month Dey Year	3. Time of Death
	/Medical	Maser C Marala		Flay 14, 2004	12:3000
	Examiner	4e Fecility Name (If not institution, give street end number)	4b. City, Town, or	r Location of Death 4c. County of Death	
		Keswick Care Center	Baltin	more N/A	
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 M F 88	Ast birthdey) Yrs.  If Under 1 Year If Under 24 Hr. Months Days Hours Mir	n. (Month, Day, Year) Cou	place (State or Foreign ntry) INSYLVania
	pue *	Usuel Residence of Decedent  10a. State 10b. County 10c. City	y, Town or Location		10d. Inside City Limits
	Menyl		altimore		1⊠Yes 2 □ No
	with the Me or 28a-fs be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	
	terrests with the Meryler terrests or 28e-f show the matter mutted at 11mers of 11mers	501 Drury Lane	21229	U.S.	
21215-0020	urs aff	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (to If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)  14. Race - Ameri Black, White,  Specify: White	etc.
5	"natural", adcal Ex	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupetion (Give kind of work done during most of wo	orkina 16b. Kind of Business/In	dustry
7	within than the Mag	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired) Administrator		
	7 7 1	12th		Social Sec	curity
Ē	d out	17. Father's Neme (First, Middle, Last)	18. Mother's Na	ame (First, Middle, Maiden Surname)	
$\frac{2}{5}$	should by and Menta marked americal		Mar		
, Maryland	d2:	19a. Informant's Name/Relationship (Type, Print) Rosemary Byron / Daughter	19b. Mailing Address (Street and Number or R 501 Drury Lane Bal	durel Route Number, City or Town, State, Zig timore, Maryland 212	
Baltimore,	permit. Peges 1 en Depertment of Heel Important: If Itam 2 any Injury or other ance.	1 Rurial 2 Cremation 3 Removal from State		Date 20c. Location - City or To 5/25/04 Baltimore,	Maryland
Ball	permit. P Depertminimportar any injure any injure	21. Signature of Funeral Service Licensee	22. Name and Address of Facility G 4001 Ritchie Highw	once Funeral Service vay Ealtimore, Mar	e, P.A. yland 21225
	A	23a. P. a. Enter the disease of complications that caused the death shock, or heart failure. Sit only one cause on each line.	. Do not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate
	Physician			·	Interval Between Onset and Death
r A	/Medical	Immediate Cause (Final disease or condition	ente mun ardino in	lar clien	5 marciles
	Examiner	resulting in death)  e  Due to (or	ente myselvala in as a consequence of: essel Cerenary with		5 minufes
	P = D	Therefiple in	essel Cerenary wit	erer disease.	1. Khoush
	eath certificate be executed attending physician end for use es the bunal-trensit for use the bunal-trensit clary/Medical Examiner	Sequentially list conditions,  Due to (or	as a consequence oi):	1	<i>yyyy</i> - 2 <i>y</i> -
Ö,	ian e urial-	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			
68760,	hysic the b	that initiated events resulting in death) Last Due to (or	es a consequence of):		
<u>ق</u> ×	ng p			1	
<b>6</b>	th ce tending or use	d			
	0 0 0	Part II. Other significant conditions contributing to death but not resul	ting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to	the cause of death?
, P.O	es that the death c igned by the attenct be detached for us by Physician.	Diahetes mellitus	se	1 ☐ Yes 2 ☑ No 3 ☐ Prol	bably 4 Unknown
Records,	requir been si should	Diahetes mellitus		performed? ava	ere autopsy findings ailable prior to mpletion of cause death?
	ding Physician: The law h. After this certificate has funeral director, page 2 funeral comp			1 1 Yes 2 1 No 1	Yes 2□No
	stan: entifice ector. J	25. Was case referred to medical	26. Place of De	ath (Check only one)	
<b>&gt;</b>	hysici his ce il direc	examiner?  1 Yes 2 No Hospitel: 1 Inpatient 2 E	Other	Home 5 ☐ Residence 6 ☐ Other (Specify	v)
o c	Attanding Physician: r deeth. sctor: After this certific by the funeral director. Ification: To Be (		28b. Time of 28c. Injury at	28d. Describe how injury occurred	<i>'</i>
0	uttendin deeth. ctor: Att y the fur ficatio	1 Datural 5 Pending (Month, Day Year) 2 Accident investigation	Injury Work?  M 1 ☐ Yes 2 ☐ No		
Division	tal or Attanding P rs after deeth. al Director: After t led in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street and Number or Rura City or Town, State)	l Route Number,
	he Hospi in 24 hou he Funer pletely fil edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know and manner stated.	edge, death occurred at the time, date and place on and/or investigation, in my opinion, death occu	i, and due to the cause(s) and manner as st irred at the time, date and place, and due to	ated. the cause(s)
	Vithing Comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, I	Day, Year)
	.\	M. Babelle / Me Gream	ma 12/3657	May 19,200	04
	X	30. Name end address of person who completed cause of deeth (Item 2			
	18		. 40 YL STREET BALTIN	70RE,000 21211	
I	State Registrar	31. Date 14 Month Day Your San 32. Registrer's Signary	re Souls		

	•	1 - For State Registrar					tificate o			Reg. <b>No</b> . 2	004	1676
Dhysieir		Decedent's Name (First, M.	iddle, Last)	)					2. Date of De. Month	ath Day	Year	3. Time of Deat
Physicia /Medic		Dorothy				Pe1	egan		May 14			2:25 A
Examin		4a. Facility Name (If not instit	ution, give s	street and numb	ber)		4b. City, Towr	n, or Location of De	eath	4c. Cou	unty of Death	
		Lorien Nursi					Colum			How		·
Funeral Director		5. Social Security Number 021-20-7018	6. Sex	х ]м 2 <b>X</b> ]F	. Age (In yrs.	76 Yrs.	If Under 1 Ye Months Day		lin. 8. Date of Birt (Month, Da March	, 1928	9. Birth Cou Mas	place (Stete or For ntry) sachuset
>0000		Usual Residence of Deceder			100 Cit	ty, Town or Lo	nation					10d. Inside City Lin
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28a-1	ect	10e. Street and Number	lingt	-011		c. Haa	10f. Zip Code			10a Citizon	of What Cou	
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ns 23	eral	11. Marital Status		12. Was Deced	lent Ever in U	.S. 13.			(Specify Yes or No		Race - Ameri	can Indian.
E E	F	1 Never Married 2		Armed Ford	es?				(Specify Yes or No lerto Rican, etc.)		Black, White	etc.
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ital Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Medical Examinat hust be notified at	Completed by Funeral Director	15. Dec	dent's Edu	cation		16a. Dece	dent's Usual Oc	cupation ne during most of	unrking.	16b. Kind d	of Business/Ir	ndustry
Med "	pje	(Specify onty h Elementary/Secondary (0-		College (1-4	4or 5+)	life.	DO NOT use ret	ired)	WOIKING			
ar th	Sof	12				Hom	emaker				n Home	
and Mental Hygiene. is markad othar than aumatic evant, the M	Be (	17. Father's Name (First, Mid							Name (First, Middle,	, Maiden Sur	name)	
arkad o	2	Louis Spring	Ler					Rose F	odlesky			
r nealln and men Itam 27 is marka othar traumatic		19a. Informant's Name/Rela							Rural Route Number			
tam 27 thar tr		Stewart Pele	gan -	Son					, Laurel,			
		20a. Method of Disposition 1 X Burial 2 ☐ Crema:	ion 3∏F	Removal from St	20b. F	Place of Dispo	sition (Name of natory or other p Genera	place)	Date	20c. Locati	on - City or T	own, State
ant: i		'4 □Donation 5 □ Oth				terans	Cemeter	ry	5/18/04			New Jer
Department of important: if any injury or once.		21. Signature of Funeral Ser	vice(Licens	99	0	22	. Name and Ad		Bradley Fu		Home	
3.E & 8	1	Mul	CC	2000 C	122				501 Rt. 73 South Mar		NJ_080	53
	//	23a. Part 1. Enter the diseas	, or compl	lications that can	used the deat ch line.	th. Do not ent	er the mode of o	tying, such as care	fiac or respiratory a	rrest,		Approximate Interval Betwee
ysician		I mediate Cause (Final isease condition resulting in death)		Dement								Onset and Deat 4 Years
ledical	V	resulting in death)		a Due to ( <i>o</i>	ras a conseq	uence of):						1 Icuio
aminer		Sequentially list conditions	1	b								
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trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	,	c								
ian a	Ě	resulting in death) cast		Due to (o	ras a conseq	luence of):						
hysic the b	lical			d							-	
ing p	Mec	IF FEMALE:		20 1/								
attending physician and for use as the burial-transit	Physician/Med	23b. Was decedent pregnar in the past 12 months?	2		th 2 🗍 Feta	aldeath 3[	Ectopic pregna			23d.	Date of deliv Month	ery Day Year
the a	SIC	1 ☐ Yes 2X No 9 ☐ Unknown		4∐Pregna 9☐Unknov	nt at time of c vn	leath 5L	Other (specify,	)				,
ned by the a	Ph <sub></sub>	Part II. Other significant cou	ditions on	atributing to des	ath hut not rac	ulting in the u	ndarhina causa	awen in Part I	23e Did to	obacco use o	contribute to 1	he cause of death
500	by	Dysphagia	ditions co	introduing to dea	itii but not res	and an ine a	ndenying cause	given in Parti.	1 🗆 1			bably 4 □Unkr
been si should	eted								-	Λ		
S CA	Completed by	Schizo Affe	tive	Disorde	er				24a. Was	osy	4b. Were auto prior to co death?	opsy findings avail impletion of cause
pag	Co									rrried? 2X No	1 ☐ Yes	<b>2√</b> □ No
i i	Be	25. Was case referred to me examiner?	-	Hamitali			- 12		Death (Check only o	one)		TTO TO
90 90	유	1 ☐ Yes 2X No				ER/Outpatier	it 3 DOA		g Home 5 ☐ Resid			fy)
this cer al direct	ü	27. Manner of Death 1 🔊 Natural 5 □ Po		28a. Date of (Month	, Day Year)	28b. Time o Injury		njury at Vork?	28d. Describe I	now injury oc	currea	
After this cer uneral direct		Z _ riodiadrit	estigation ould not be		** * **		- 3	☐Yes 2☐No	206 Leasting /	Caro as an of \$1.	umbas as D.	al Davido Alverba a
n. After this funeral di	catle		termined	28e. Place o building	of Injury - At h g, etc. <i>(Speci</i>	ome, tarm, sti fy)	eet, factory, offi	Ce	City or Tox		umber or Hun	al Route Number,
n. After this funeral di	rtificati	1 2 1 1011110100	11	Total					())	(1)		
n. After this funeral di	l Certification:		that - Ohai		sis of examina				ace, and due to the courred at the time,			
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After this funeral di		29a. Certifier 1X Cer (Check only 2 ☐ Med one)	ical Exemi	and manne			29c. Lice	ense number		29d. Date si	aned (Month.	Dav. Year)
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within 24 hours after death.  To the Funeral Director. After this cercompletely filled in by the funeral director.		29a. Certifier (Check only one) 2 Med 2 Me	rtifier	and manne	~ n			9 5 65		mai		) 2004
n. After this funeral di		29a. Certifier 1X Cer (Check only 2 ☐ Med one)	rtifier	and manne	~ n		Print)	565		mai	1 14	,2000

			1 - State Registrar	te of Maryland / De	epartment of Health and Certificate of Death		ene 2004	16766
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ang & ID All	ic E		2. Date of Death Month May 2	Day Yeer 1, 2004	3. Time of Death 5:10 AM
7	Examir Funeral Director		4a. Facility Name (If not institution, give street a MeMoRC of 5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last birtho	Months Days Hours Mir	s. 8. Date of Birth	4c. County of Death    County of Death   Sirth County   Property   olace (State or Foreign ntry) M. / )	
	ehow		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town o				10d. Inside City Limits
	he Ma 28a-f	Director	M.D N/A  10e. Street and Number	Balta				1 Yes 2 No
	3a or	i i	6607 Old Aproford	noul	10f. Zip Code	Tog	Citizen of What Could	•
36	72 hours after death with the Maryland natural', or Itema 23a or 28a-f ehow disal Exaciliar imali be incilited at	by Funeral	11. Marital Status 12. Wa An 1 Never Married 2 Married 1 It It It It It It It It It It It It It	s Decedent Ever in U.S. ned Forces? ]Yes 2 PNO es, Give ar or Dates:	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 ☐ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: 3/A-C	can Indian, etc.
21215-0036	within ane. then	Completed	15. Decedent's Education (Specify only highest grade comp	/eted) 16a. Di (C) (d) (d) (d) (d)	ecedent's Usual Occupation live kind of work done during most of wo fe. DO NOT use retired)	orking	b. Kind of Business/In	dustry
and 2	2 should be filed with and Mental Hygiene. Ie marked other ther aumatic event, the	To Be Co	17. Father's Name (First, Middle, Last)  GEURGE BEST	<i>D</i>   <i>B</i>		ame (First, Middle, Ma		
Maryland	DEN =	-	19a. Informant's Name/Relationship (Type, Pri		lailing Address (Street and Number or F	Jural Route Number, C	City or Town, State, Zip	
Baltimore,	Pages nent of ant: If it ury or o		20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I from State cemetery,	sposition (Name of crematory or other place)  Lemeter 5/ 22. Name and A dress of Facility	Date 20	c. Location - City or To	own, State
Bal	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee	L	22. Name and A dress of Facility  [1] 1139 N. CAKOLINE 6	2 BAltim	NE MD ?	21213
	Physician /Medical Examiner	ler	Sequentially list contribitors	that caused the death. Do not se on each line.  Werwhelming four to (or as a consequence of):		ac or respiratory arrest		Approximate Interval Between Onset and Death Two days
68760,	death certificate be executed e attending physician and yd for use as the burial-transit	edical Examiner	that initiated events C.	due to (or as a consequence of):				
О. Вох	death certiff e attending ed for use as	Physiclan/Me	in the past 12 months?	es, outcome of pregnancy Live birth 2 Petal death Pregnant at time of death Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
rds, P.	law requires that the d as been signed by the 2 should be detached	þ	Part II. Dther significant conditions contribution	ng to death but not resulting in th	e underlying cause given in Part I.		cco use contribute to the	
of Vital Records,	The lay ate has page 2	Completed				24a. Was an autopsy performe 1 Yes 2	d? prior to coi	psy findings available mpletion of cause of
Σ	Physician: rthis certificant all director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No Hospita	1 XInpatient 2 ☐ ER/Outpa		eath Check on one Home 5 Residence	e 6 ∏Other (Specifi	iv)
Division o	ding h. After fune	Certification:	1 Natural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	28d. Describe how		
Divi	ital or Atten irs after deat ral Diractor: led in by the		4 Homicide determined 288	Place of Injury - At home, farm building, etc. (Specify)		City or Town, S		
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	Medical	one) 2 Medical Exeminer: Of	To the best of my knowledge, do the basis of examination and/od manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occurrence.	urred at the time, date	and place, and due to	the cause(s)
	To To		29b. Signature and title of certifier  Kun Frank		29c. License number AT 2438946		Date signed (Month, ay 21, 20	
			30. Name and address of person who complete Kun Frank Lu. M.D., 201	d cause of death (Item 23a) (Ty Eûst University	pe. Print) Parkway, Baltimore	Maryland	21218	
	Sta Registr	te ar	Kun Frank Ly, M.D., 201 31. Date filed (Month, Day, Year) MAY 2 6 2004	32. Registrar's Signature	South to			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 16767 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** PEARCE JOSEPH 6.56 P.M RTHUR 2 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIMORE CARE FACILITY RALTIMORECIT A. EXTENDED If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/15/1934 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1XM 2□ F Director 70 212-32-8753 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Heatih and Mental Hyglene.
and: If Item 27 is marked other than "naturel", or Itams 23a or 28e-f show any or other traumatic event, Ite Medical Expris mentions maillised at any or other traumatic event, Ite Medical Expris mentions maillised at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo MD Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9229 Cowenton Avenue 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No 1956— If Yes, Give Year or Dates: 1958 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 10 Cook 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Clarence William Pearce Grace Catherine Tremper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7627 Chapman Road - Kingsville, Maryland 21087 May L. Sparr (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Gardens of Faith 05/27/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused h shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Cel Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) detached t the 9□ Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by pa 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2 ☐ No 200 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DOA Certification: To 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attanding 1 Natural 5 Pending Injury 2 🗌 No 1 Yes investigation 2 Acciden To the Funaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

within 24

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only

29b. Signature and title q

30 Name and address of person

31. Date filed (Month, Day, MAY 2 6

rtifier

one)

who completed cause of death (Item 23a) (Type, Print

32 A

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

			State of Maryland / Depa	rtment of Health and M	lental Hygie	- 7 H H L	16768
			Registrar  1. Decedent's Name (First, Middle, Last)	uncate of Death	Reg. 2. Date of Death	No O O	3. Time of Death
	Physici	an	William Camille Pierne			Day Year	7:18 PM <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	7.10 111
	Examin	er	1004 C Downing Court	Bel Air		Harford	
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	0 Pieth	lace (State or Foreign
	Director		218-52-1004 <sup>1</sup> X <sup>M</sup> <sup>2□ F</sup> 57 Yrs.	Months Days Hours Min.	Month, Day, Ye May 5, 1	947 Mary	
	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc				Od Incide City Limite
	shov	_		ation		'	0d. Inside City Limits 1 ☐ Yes 2 💆 No
	88a-1	Director	Maryland Harford Bel Air	10f. Zip Code	100	Citizen of What Cour	
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show deal Examinations to cellified at		10e. Street and Number		109.		itty!
	ns 23	Funeral	1004 C Downing Court.  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21014 Vas Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Americ	an Indian
	ter d	Š	Armed Forces?  1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
99	urs af	ρ	3 Widowed 4 Divorced Year or Dates:	☐ Yes 2 No Specify:		Specify: US.	Δ
Ö	72 ho	Completed	15. Decedent's Education 16a. Deced	ent's Usual Occupation	in a 168	o. Kind of Business/Inc	
215	C * N	nple	(Specify only highest grade completed) (Give I Elementary/Secondary (0-12) College (1-4or 5+)	sind of work done during most of work OO NOT use retired)			
21	filed within Hygiene. other than "	S	<u> </u>	acher	·	Public Edu	cation
nd	be filed within 72 hours after death with the Marylan hat Hygiene.  Id other than "natural", or Items 23a or 28a-f show or other than "natural", or Items 23a or 28a-f show event, the Marical Examination in the collinar at	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
Ya	2 should be filed withir and Mental Hygiene. Ia marked other than aumatic event, ma M	은	Andrew Camille Pierne	Marydel.		nn) Funk	0.43
Maryland 21215-0036		H		g Address (Street and Number or Run			Code)
	item 27	1	Nancy Pierne - Wife 1004 20a. Method of Disposition 20b. Place of Disposi	C Downing Court,	Eel Air,	MID 21014 c. Location - City or To	wn, State
Baltimore,	Pages nent of H ant: If ite ury or of		1 ⊠Burial 2 □Cremation 3 □Removal from State	atory or other place)			
틒	permit. Pages Department of Important: If i any injury or once.		'4 □ Donation 5 □ Other (Specify) Moreland  21. Signature of Funeral Service Licensee 22.			arkville, M neral Home	
Ba	Dep imp		14.0 6.01	317 Cokesbury Road			
			23a. Pairt. Enter the disease, or comblications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate
	Pnysician			_			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a	ung Carcinon			18 men.
	Examiner		Sequentially list conditions b.				
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury				
	nd	Examiner	that initiated events				
760,	ite be executed ysician and ne burial-transit		resulting in death) Last Due to (or as a consequence of):				
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9 xo	ding l	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of deliver	1
Bo	death certifica attending ph for use as th	clan	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	Day Year
0	that the deby the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	77			
Δ.	that hed b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
rds	quires in signe				1 ☐ Yes	2 No 3 Prob	abiy 4 🗍 Unknown
Records,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Completed			24a. Was an	24b. Were auto	psy findings available inpletion of cause of
æ	The lav	E O			autopsy performed	death?	
Vital		BeC	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)		
of V	di S	LO.	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		me 57 Residenc	e 6 □Other (Specify	1)
		.i.o	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury Injury 28b. Time of Injury 2b. Time of Inj	28c. Injury at Work?	28d. Describe how	injury occurred	
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Division	i Dite	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, streething building, etc. (Specify)	eet, ractory, office	City or Town, S		r noute rumber,
_	To the Mospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death	occurred at the time, date and place	and due to the caus	e(s) and manner as st	ated.
	e Hos 24 h e Fur etely	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or inv				
	To th within To th	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	Day, Year)
			Clearles Padgettus>	D15546		May 21, 2004	
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, I				
_	1.0		Charles bedgett MD, 5601 Lock Ravey Biv	el, Baltimora, Lu	21239		
	Sta		31. Date filed (Month, Day, Year) MAY 2 6 2004  32. Registrar's Signature				
	Regist	rar	MIST & D 2004 Streve &	Sparks			

State of Maryland / Department of Health and Mental Hygiene 2 1 1 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Anne Rose Pecukonis **Physician** May 3:00 P. M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie 7925 Roxbury Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 13,1915 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 ☐ M 2 🕇 F 89 Michigan 212 32 2885 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Examinar must be multified at 1 Yes 2 No Director Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. 21060 7925 Roxbury Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No 1 X Never Married 2 ☐ Married White 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: Specify: Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) John Hopkins Hospital permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene important: if item 27 is marked other tha any njury or other traumatic event, Ital 2005. Nurse 5+ years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Sczygola Vincent Pecukonis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Frank Pecukonis Sr./ Brother 109 Doris Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 5/26/2004 Baltimore, Maryland Holy Cross Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. Baltimore, Maryland 21225 ceome 4001 Ritchie Highway 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arr 5445 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ty Per tensur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of) Examiner bebrillaten Trs The law requires that the death certificate be executed use as the burial-transit Paroxy Smal signed by the attending physician and J be detached for use as the burial-traresulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 3 Probably 4 Unknown 1 Yes 2 No peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes 2 No 1 Yes certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier t 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cedifier NO 09 5.24.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park Colon Borny 21061 Moder on 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 6 2004 Registrar

			1 - For State Registrar	State of Maryla	nd / Dep	artment of H	Health and	Mental Hy	000	
					Ce	rtificate of	Death		Reg. No.	
	Physici /Medic		Decedent's Name (First, Middle, Last)     Martha Theresa I					2. Date of De Month	Day Y	3. Time of Death
1	Examin	er	4a. Facility Name (If not institution, give s	11	71	0	or Location of Dea	th	4c. County of	
			5. Social Security Number 66. Sec	ARE HOSPI	. last birthday)	If Under 1 Year	e dale	8. Date of Birt	13411	MORE  Birthplace (State or Foreign
	Funeral Director			M 2□k 77	Yrs.	Months Days	Hours Min		y, Year) 7.1927 N	Country)  State of Foreign Country)
	PL ,		Usual Residence of Decedent					, ipiti	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examiner must be mallied at	ū	10a. State 10b. County  Maryland Baltimon		ity, Town or Lo Iiddle 1					10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	rect	10e. Street and Number		Huare 1	10f. Zip Code			10g. Citizen of Wh	
	3a or	by Funeral Director	328 Grovethorn Rd.	•		2122	20		USA	at oddiny:
	death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No	- 14. Race -	American Indian,
36	or Ito	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ∑XNo If Yes, Give		1 ☐ Yes 2 🕱 No		to ritali, etc.)		White, etc. White
21215-0036	hours tural'	q pa	3 XWidowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		dent's Usual Occur				
15	in 72 n "na Nedic	Completed	(Specify only highest grade	e completed)	(Give	kind of work done DO NOT use retire	during most of wo d)	rking	16b. Kind of Busi	ness/industry
212	d with giene er the	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Ho	usewife			Own Hom	е
nd	al Hy al Othe	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
yla	ould the Ment	T <sub>o</sub>	John Henry Nuth		1				Schindle	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show amportant: If item 27 is marked other than "natural; or items 23a or 28a-f show appring try or other traumatic event, this Madical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty) Theresa Lloyd (Dat						or, City or Town, St Nore, Md.	
ore,	ss 1 a of Hea litern r othe		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location - Ci	ty or Town, State
Ĕ	Pagement ant: It ury o		1 ⊠ Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	HC HC	olly Hi	ll Mem. (	Cardens 5	/28/2004	Baltimor	e, Maryland
Baltimore,	permit. Depart Import any inj pnce.		21. Signure of Funeral Service License	o Q Q	22	2. Name and Addre	ss of Facility Ski Funer	al Home	P.A.	
	40340		23a Part1. Enter the disease, or compli	trouske					Ssex, Md	. 21221 Approximate
	Dharistan		Immediate Cause (Final	ne cause on each line.			ig, sucii as caigia	c or respiratory ar	rest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse		TROKE				3 DAYS
	Examiner		Sequentially list conditions	)						
	pe is	Examiner	t any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quanca of):					
	and Il-tran	xam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
8760,	ate be executed hysicien and the burial-transit	cal E			4001100 01/1					
9	g phy: as the	edic								
Вох	th certiendin	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,		23d. Date of	/
E	es that the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of of 9☐ Unknown		Other (specify)			Month	Day Year
P.O.	that the	Phy	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I	23a Did to	bacco use contribi	ute to the cause of death?
Records,	The law requires that the death certifics tie has been signed by the attending pt page 2 should be detached for use as t	d by			•	, <b>,,,</b>		1 🗆 Y		□ Probably 4 □Unknown
CO	w requir s been si should	olete						24a. Was a	an 24b. We	re autopsy findings available
Re	ilcien: The lav certificate has rector, page 2	Completed						autop perfor 1 Tes	med? dea	r to completion of cause of th?  Yes 2□ No
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of V	hysic this ce	ဥ	1 ☐ Yes 2 No		ER/Outpatier		4   Indianing i		ence 6 Other	(Specify)
Division of	Jing F	:lon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred	
isi	Attender death	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	nome, farm, str		192 5 140	28f. Location (S	treet and Number	or Rural Route Number,
<u> </u>	el or s s efter il Dira	Certification:	4 Homicide	building, etc. (Speci	ify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tow		
	To the Hospitel or Attending Physicien: The I within 24 Hours elder death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier Certifying Phys	sician: To the best of my knowner: On the basis of examina and/manner stated.	owledge, death ation and/or in	n occurred at the tir	ne, date and place pinion, death occu	e, and due to the durred at the time, of	ause(s) and mann date and place, and	er as stated. I due to the cause(s)
	o ths	Med	29b. Signature and title of certifier	andmanner stated.		29c Licens	e number	2	29d. Date signed (M	Month, Day, Year)
•	->-0		) JTY/WY <	Javeny		NAS	e number		5-24-	2004
	10		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)			0 0-1	<i>5-0-0</i>
	, -		DR. STephen Seli	Nger 90001	FRANK	lin Sq.	HARE DI	2. 13AIT	I MORE,	Md. 21237
	Sta Registr	- 5	31. Date file (146) 4. 2ay (3 e 2) 0 4	34 Registrar's Sign	ature	Sports			,	Md. 21237

		1 - For State Registrar	State of Marylar		artment of H		Mental Hy	200	ls 16771
Physic		1. Decedent's Name (First, Middle, Last) Antoinette	В.		Rogers	5	2. Date of De Month 5	eath	3. Time of Death 5:07a
/Medi Exami		4a. Facility Name (If not institution, give s	street and number)			Location of Death		4c. County of	
Funeral Director		5. Social Security Number 6. Sex 217–38–7289 Usual Residence of Decedent	7. Age (In yrs.	. last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 7-10	rth ay, Year)	Birthplace (State or Foreign Country)
Maryland a-f show	ctor	10a. State 10b. County  Md. NA	10c. C	ity, Town or Lo	cation				10d. Inside City Limits  1 Yes 2 □ No
ath with the 23a or 28 ust be not	rai Director	10e. Street and Number 5432 Force Rd.			10f. Zip Code 21206	5	30.0	10g. Citizen of Wh	at Country?
ING 21215-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "netural", or Items 23s or 28s-f show event, the Mcdical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∏ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		American Indian, White, etc. Black
d 21215-0036 filed within 72 hours af Hygiene. Hygiene."natural; or hth, Ire Medical Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of work )	ing	16b. Kind of Busin	,
	To Be Co	12th grade  17. Father's Name (First, Middle, Last)  Frank	Bro		ses Assit		e (First, Middle	Future Co. Maiden Sumame) Blackst	
Mark 27 11 12 17 17 17 17 17 17 17 17 17 17 17 17 17	-	19a. Informant's Name/Relationship (Type Myra Brown		19b. Maili	ng Address (Street a	and Number or Run		per, City or Town, St	ate, Zip Code)
Page Page ment o ant: If ury or		20a. Method of Disposition  1	emoval from State	cemetery, crei Oshell	natory or other place	5-25	-04	20c. Location - Ci  Dundalk	
Departition Departition of the proof of the		21. Signature of Juneral Service License	Walter on	/ M	2. Name and Addres	East	1101	more, Md. E. North	
Physician /Medical		23a. Party Enter the disease, or complishers, or heart failure. List only or impediate Cause (Final disease or condition resulting in death)	ne cause on ead fine.  Due to (or as a consec	pane	rentice mode or dying	Cardiac C		irrest,	Approximate Interval Between Onset and Death
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8760, rate be executed hysician and the burial-transit	licai Exar	that initiated events resulting in death) Last	Due to (or as a consect.	quence of):					
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	ate	30. Name and address of person who co	301 St. Paul f 32. Registrar's Sign	bresu		Baltimo	e, mai	yiand 21	203-
Regist		MIX 2 6. 2004	Bonera	ORIGINA	Sparks	,			

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	/Medic	cal		lriguez	umbor)		4h Cih	Town or	r Location		y 21,		y of Death	
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	Euporal		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under	1 Year	If Under	24 Hrs. 8. D.	ate of Birth			
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_	pu ,		Usual Residence of Decedent		100	City, Town or L								10d Japida Cita Lineira
	shov	5	10a. State 10b. County		100.			_						10d. Inside City Limits  1 ☐ Yes 2 ☐ No
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	with se or	급	28 State Cour	-t				0877	7			Unite		
	deeth ms 2;	era	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.				igin? (Specify ) n, Puerto Rican	es or No-		ce - Ameri	ican Indian,
g	after or Item	T.	1 ☐ Never Married 2 📉 Ma		Forces? s 255No Give				an, Mexicai Specify:		, e(C.)		ack, White	
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2	be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. d other than "naturel", or items 23a or 28a-f show event, I'te Mariful Examiner and be notified at	Be Completed by	17. Father's Name (First, Middle	, Last)	_				18. Moth	er's Name (Firs	t, Middle,	Maiden Suma	me)	
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Baltimore	permit. Pages: Department of H Important: If ite any injury or of		21. Sign, are of uneral Service	-	160	2	2. Name an	d Addres	ss of Facili	ity	1 1	0		2
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od riguez	aw re	Completed								2	4a. Was a		Were auto	opsy findings available ompletion of cause of
P		E O								1	perfor	med?	death?	
Co	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medic examiner?							e of Death (Che	ock only or	ne)		Hognico
	this al di	ဥ	1 ☐ Yes 2 🛣 No 27, Manner of Death			ER/Outpatie	_		4 L NL	ursing Home		ence XXOt		Hospice Home
		lon	1 XNatural 5 ☐ Pend	ing (M tigation	te of Injury onth, Day Year)	28b. Time of Injury	M Z	8c. Injun Wor	yat k? Yes 2. □		Sescupe III	ow injury occu	rred	100/100/100/20
Division	l or Attendi after death. Director: A d in by the fu	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Pla	ice of Injury - A	home, farm, st				28f. L	ocation (S	treet and Num	ber or Run	al Route Number,
	spitel or Al ours after of herel Direc	Certification:	4  Homicide	bu	ilding, etc. (Spe	cify)					ity or Tow	n, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune to	623	(Check only 2 Medica	ing Physician: To I Examiner: On the	the best of my keep basis of exami	nowledge, dear	th occurred	at the tin	ne, date ar	nd place, and death occurred at	ue to the c the time, d	ause(s) and m	anner as s	stated. to the cause(s)
	thin 24	Medica	one) 29b. Signature and title of certifi	and m	anner stated.				e number			29d. Date sign		
	7 × × ×	Ħ	> SA	12		* X		D09				May 2		
	1		30. Name and address of person	n who completed ca	<u> </u>	tem 23a) (Type	Print)					, ,		
	<b>b</b>		Dr. E. P. Li		10400 C			venu	e Ken	singtor	ı, MD	20805	5	
	Sta Regist	ate rar	31. Date filed (Month, Day, Yea MAY 2		. Registrar's Sig		Ko	ak.						
			וווחו גע (	4004	10 1-		jugo	and,	forth and					

			1 - For State Registrar		-	epartment of Certificate of			Reg. No 2001	16773
	Physici /Medic		Decedent's Name (First, Middle,     Darwin		Sanders_			2. Date of Dea Month May 24	Day Yea 2004	6:29 pm <sup>M</sup>
	Examin Funeral Director	ier	4a. Facility Name (If not institution, Franklin Square 5. Social Security Number 212–36–6455	Hospital	(In yrs. last birth	Rossvi	r If Under 24		Baltimon  th y year) 1938 Mar	
ne Maryland	8a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltim	ore	10c. City, Town Middle	River				10d. Inside City Limits 1 ☐ Yes 243(No
ath with th	23a or 2 ust be no	Funeral Directo	10e. Street and Number 7231 Greenbank Ro	oad		10f. Zip Code 21 2.	20		10g. Citizen of What U.S.A.	
should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23s or 28s-f show any rightry or other traumatic event, the Modical Examination at any rights.	by	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces?  1 □ Yes 2 汉N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cui		i? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. White
within 72 ho	ene. than "natur ne Madical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5-	-)	Decedent's Usual Occu Give kind of work done life. DO NOT use retir ner/Operato	e during most of ed)	f working	16b. Kind of Busines Trucking	ss/Industry
uld be filed	Mental Hygi arked other atic event, II	To Be Co	17. Father's Name (First, Middle, L Paul Clay Sande				18. Mother's	Name (First, Middle, Naomi Sin	Maiden Sumame)	
, ivial ) and 2 sho	ealth and I		19a. Informant's Name/Relationshi Virginia Sanders		72	Mailing Address (Stree 31 Greenbai		, Baltimor	e, Marylar	nd 21220
Pages 1	nent of He ant: If iten ary or oth		20a. Method of Disposition  1 □ Burial 2 ▼Cremation  4 □ Donation 5 □ Other (Sp.		cemetery	Disposition (Name of r, crematory or other pl w Crematory		Date y 26,2004	Baltimore,	
	Departr Imports any inji	$\in$	21 Signature of Fureral Sanies 1  a. Fart1 — The disease, or or show or heart failure. List of Immeriate Cause (Final disease or condition	omplications that caused	the death. Do no	ot enter the mode of dy	Flasterr ving, such as car	n Avenue,	rrest,	A.  "Yland 21221  Approximate Interval Between Onset and Death
	been signed by the attending physician and ingless should be detached for use as the burial-transit a.	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence o	n: s Me n: LHOLES	LLI TU	( S		
the death certific	y the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of d Month	lelivery Day Year
law requires that	en signed by	by	Part II. Other significant condition	Scontributing to death but		the underlying cause g	A			to the cause of death? Probably 4 □Unknown
al neco	ate has page 2	Completed						24a. Was autop perfor 1 □ Yes		
SION OI VII	within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No    27. Manner of Death   Natural   5 Pending   2 Accident			me of 28c. Injury	ther: 4 Nursir	28d. Describe h	nne) dence 6 □Other (Sp now injury occurred	pecify)
DIVISI tal or Atter	rs after dea al Director ed in by the	Certification:	3 Suicide 6 Could not determine		ry - At home, far . (Specify)	m, street, factory, office	9	28f. Location (S City or Tow	Street and Number or wn, State)	Rural Route Number,
he Hospi	in 24 hour the Funer pletely fill	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination and	Vor investigation, in my	opinion, death o	occurred at the time,	date and place, and d	ue to the cause(s)
ToT	with com	M	29b. Signature and title of certifier	PConnelly	3 MM	P	30133		29d. Date signed (Mo 5/25/1	A
	5 Str	ate	30. Name and address of person was a second of the second	onnelly b	4.4	Type, Print) V.I. SEAC	on Ro	BALT	more	21220
- *·	Regist		MAY 2 6 20	na helen	a 4	1	,			

DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland	/ Depa	artment of F	Health a	and M		giene 2 Reg. No.	004	18771
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Mary K. Starr					2. Date of De.	ath Day	2004	3. Time of Death 5:35 A M
	Examir		4a. Fecility Name (If not institution, give street and number) University of maryland medical Co	enter		imer	e,n	1 ARY LMN	rO	unty of Deeth	
	Funeral Director		5. Social Security Number  215-32-7684  Usuel Residence of Decedent	t birthday) Yrs.	If Under 1 Year Months Days	If Under : Hours	24 Hrs. Min.	8. Date of Bin (Month, Da 7/31/1	y Year) 939	Cou	place (State or Foreign ntry) (land
	Maryland a-f ehow	ctor	10a. State 10b. County 10c. City, T PA York De 1		ocation						10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 512 Main Street, PO Box 336		10f. Zip Code 1731	4			10g. Citizen USA	of What Cou	ntry?
900	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Ptygiene. Importent: if Item 27 ie marked other then "neturel", or Items 23a or 28a-f show styl injury or other traumatic event; if a Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forcas?  1 Never Married  17. Was Decedent Ever in U.S. Amed Forcas?  18. Was Decedent Ever in U.S. Amed Forcas?  18. Was Decedent Ever in U.S. Amed Forcas?  19. Was Decedent Ever in U.S. Amed Forcas?		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 No		gin? (Spe , Puerto I	cify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Whit	etc.
Maryland 21215-0036	d within 72 h giene. er then "netu	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1·4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ctary	during most	of workin	ng		servi	
yland	should be file nd Mental Hy marked oth umatic event	To Be (	17. Father's Name (First, Middle, Last)  Joseph Klien			Ruby	y Rut	(First, Middle, therfor	d		
e, Mar	i end 2 sh fealth and im 27 ie m her traum		Jackson Starr/Husband	PO Bo	ng Address (Street DX 336, D	elta,	PA	17314			
Baltimore,	il. Peges ritment of h rient: if its njury or of		1 Burial 2 Cremation 3 Removal from State Came	e cre	sition (Name of natory or other place matory		5/2	1/2004	Leo1a	on - City or To	own, State
Ba	Depermit. Depertrimporte Importe eny inju		Edephus ! Torrelely	Ha	Name and Addre	ral Hom	e,Inc			Celta, F	
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequent)	ca of).		· w =	cardiac oi	r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	physicien and ph	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last  b.   Multi ergo  Due to (or as a consequence)  C.   Due to (or as a consequence)		Failure Failur	e					months months
.O. Box 68	The law requires that the death certificate be executed the been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de-	ath 3	Ectopic pregnancy Other (specify)	′				Date of delive	ory Day Year
ds, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resultin	g in the un	nderlying cause give	en in Part I.		23e. Did to			ne cause of death?
l Records,		Completed	Endstage Renal Disease					24a. Was a autop: perfor	sy	death?	psy findings available inpletion of cause of
Viita	ysicien: The is certificate he director, page	Be	25. Was case referred to medical examiner?				of Death	(Check only or			<b>9-3</b> 10
o	Phys this ral dir	10		Outpatient		4   Nur		e 5 Resid			)
Division of	or Attending Physicien: after death. Director: After this certifice in by the funeral director.	Certification:	1 ★Natural 5 Pending (Month, Day Year)  2 Accident investigation  3 Stricte 6 Could not be	b. Time of Injury		yat k? Yes 2 ☐ N	lo	8d. Describe h			
N N	pital or A		4 Homicide determined 200. Place of Injury - At nome, building, etc. (Specify)					City or Town	n, State)		l Route Number,
	To the Hospital or Attending Ph within 24 hours alter death. To the Funeral Director: Aller th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled (Check only one)  1 Medical Examiner: On the basis of examination and manner stated.	and/or inv	estigation, in my op	pinion, death	place, ar occurre	d at the time, d	ate and place	e, and due to	the cause(s)
	T.M.		I garie larmelle				5815	3059	lay;	ned (Month, I	2004 21202
	8		30. Name and address of person who completed cause of death (Item 23: MARIE - CARMELLE ELIE 2  31. Data filled (Month Pay York)	2 31	outh Gr	REEN	8 3	I BAL	TIMOK	E, MI	21202
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Year 9:00 PM Genevieve. Loretta Semenkow MAY 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timore Baltimore City Samoritan Hospi MD 21233 9000 La If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min Social Security Number 8. Date of Birth (Month, Day, Year) Merch 6 1920 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 220 07 4446 Director Baltimore, Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits : If item 27 is marked other than "neturel", or items 23e or 28e-f show or other treumatic event, the Medical Examinal must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Cedar Crest Court 21040 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔯 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VA Housewife Housekeeping own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Thomas Loretta Zengraf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trau Donna M Bolling 705 Cedar Crest Court Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St Joseph Ch. Cem. May 28 2004 Baltimore, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Lassann Funeral Home Inc 101104 7401 Relair Road Baltimore, Maryland 21236 23a. Part1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Leath Immediate Cause (Final disease or condition resulting in death) **Physician** Portu /Medical Due to (or as a consequence of) **Examiner** Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Dienknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ HO 24a. Was an autopsy performed? 1 🗌 Yes 2 ₩ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 20 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Baltimore, SALAMI 5601 Loch Roven 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 6 2004 MAY Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

			For State			d / Dep	artment of F rtificate of	lealth and I	Mental Hy	20114	16776
			Registrar  1. Decedent's Name (First, Middle, Last				timoate of	Death	2. Date of De	Reg. No.	3. Time of Death
I	Physici	an	Roy Byrd Staton						Month	Day Year	
5	/Medic						th City Town	al anation of Donat	May	17 2004	2315 PM <sup>M</sup>
10	Examin	er	4a. Facility Name (If not institution, give					r Location of Death	1	4c. County of Dea	ın
5			Harford Memorial			lance beingbruten.	Havre de		Dota of Die	Harford	
33	Funeral Director		5. Social Security Number 6. Se 226-32-7167 15	K 2□F 7. AG	76	last birthday) Yrs.	Months Days	Hours Min.		y, Year) Co	thplace (State or Foreign puntry) ginia
7	and		10a. State 10b. County		10c. Cit	y, Town or Le	ocation				10d. Inside City Limits
5/17/04	ith the Marylar or 28a-f show	ō	Maryland Harfor	3	Be	elcamp					1 ☐Yes 2√2 No
1	the M 28a-f	ect	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	
2	E o E	늅	1304 Cranesbill C	ourt Ini	+ 10	2	21017	7		USA	out it y !
4)	death with the Maryland ms 23a or 28a-f show rmust be rediffed at	<b>Funeral Director</b>							anaite Van an Na		rices Indian
	er de Item	Ĕ	11. Marital Status	12. Was Decedent Armed Forces 1 XYes 2	3	.s. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	- 14. Race - Ame Black, Whi	
36	s aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Tear or Dates	% 103 7ietna	em em	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
5-0036	hour fural	DE T	15. Decedent's Edu				dent's Usual Occup	etion		16h Kind of Business	(In december)
7 7	"na"	lete	(Specify only highest grad	e completed)		(Give	kind of work done  DO NOT use retired	during most of wor	rking	16b. Kind of Business	nnoustry
12	within 72 hours after ene. than "natural", or Ite he Medical Examina	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)					U.S. Gover	nment
1 7 7	should be filed within the Mental Hygiene. marked other than matic event, the Manalle event.		17. Father's Name (First, Middle, Last)			Plast	er Sergea		ne (First, Middle,	Maiden Sumame)	THICH I
ı E	ould be filed Mental Hygi arked other attc event, I	Be	Walter Loving Sta	ton					etrice (		
C 5	should ind Men a marke umatic	ဥ	19a. Informant's Name/Relationship (T			10h Maili	na Address /Street			er, City or Town, State,	Zin Codo)
32 - Maryland	2 2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3		Lorraine Staton/W			1					p, MD 21017
ن ا	of Health I Item 27		20a. Method of Disposition		20b. P	lace of Disp	osition (Name of	Ţ.	Date	20c. Location - City or	
226 - Baltimore,	Pages nent of I int: If It		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	<b>)</b>	-	matory`or other plac n Nat'1 C		8-04	Arlington,	777
~ =	artme ortan injur		21. Signature of Funeral Service License		<u> </u>		2. Name and Addre		0 04	ALLING WII,	VA
Ba	permit. Pages I Department of H Important: If Ite any injury or ot 20029.			- /		3.6	A	7	me, P.A.		00
			23a. Part 1. Enter the disease, or compositors Composition Composi	ications that cause	d the deat	h. Do not en	317 Cokes ter the mode of dvir	bury Roa	d, Abingo or respiratory a	non, MD 210	Approximate
			shock, or heart failure. List only o	ne cause on each I	line.		,				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)				OF T	1+6 L	1109	1	moni/h)
	Examiner			Due to (or as	s a conseq	uence or):					
10		e.	Sequentially list conditions if any, leading to immediate	b. — Due to (or as	s a conseq	uence of):		-			
MI	betr Trisit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
,	be executed ician and burial-transit	Xal	that initiated events resulting in death) Last	c. Due to (or as	s a conseq	uence of):					
092	e be e /siciar e buri	cal		d							
282	eath certificate be executed attending physician and for use as the burial-transit			y							
Box 68	certi nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of de	livery
й	eath atter	cia	in the past 12 months?	1□Live birth 4□Pregnant a			⊒Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
00	that the d ed by the detached	Physician/Med	9 Unknown	9□ Unknown							
7	lires that signed b	by PI	Part II. Other significant conditions co	ntributing to death I	but not res	ulting in the	inderlying cause giv	ren in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Sp	quires n sign ald be	D D	- Pulmors	+124	トカ	2051	)		1 🔛	Yes 2□No 3□P	robably 4 Unknown
O C	s been s should	Set	Cohowa	m h	10	7	DISCA	50	24a. Was	an 24b. Were a	utopsy findings available
~ & &	The law requires that the death certificat are has been signed by the attending phypage 2 should be detached for use as the	ompleted	00,010,0		-)	-(				ormed? prior to death?	completion of cause of
tal		Ö	25. Was case referred to medical					26 Place of Dea	1 ☐ Yes ath (Check only o		2 No
>~	Physician: r this certific ral director,	To B	evaminer?	lospital:	ient 2	ER/Outpatie	nt 3 DQA Oth			dence 6 Other (Spe	icify)
0	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time o	of 28c. Injur	y at		how injury occurred	ony)
l no	nding:: Afte	at lo	1 Matural 5 Pending 2 Accident investigation	(Month, Da	ay rear/	Injury	Wor M 1 □	Yes 2 □No			
ATI	l or Attendi after death. Director: A i in by the fu	Hice	3 Suicide 6 Could not be determined	28e. Place of In	njury - At h	ome, farm, st	reet, factory, office		28f. Location (	Street and Number or R	ural Route Number,
	al or afte Dire	Certification:	4   Homicide	building, e	tc. (Specif	у)			City or To	wn, State)	
5	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledical (	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best iner: On the basis and manners	of examina	wledge, dea tion and/or in	th occurred at the tin	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated.  to the cause(s)
	ro the within Fo the	Me	29b. Signature and title of certifier		0 01	<u> </u>	29c. Licens	se number		29d. Date signed (Mon	h, Day, Year)
	s ō		Il de la la	np 14	11		D14	036		may 18,2	-004
	cxl		30. Name and address of person who o	ompleted cause of	death (Iter	n 23a) (Tvoe	Print) P =1	SE P		SANTOS,	
	KII		2835 cHurch		oac	/	cHyrel				1028
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	trar's Signa		Spark	2/	× -	1	
	Regist	rar	MAY 2 6 20	U4 /1			//				

STANTLEY	ľ	For State Registrar	State	of Maryla				lealth a Death		ental Hy	giene Reg. No.	004	16777
		1. Decedent's Name (First, Midd	lle, Last)							2. Date of De	eath	V	3. Time of Death
Physicia /Medic		Stan Rex Stanl	Ley							Month MAY	23, 20	004	3:21 P <sup>M</sup>
Examin		4a. Facility Name (If not institution UPPER CHESAPEA)			R		, Town, or LAII	Location o	of Death			unty of Death RFORD	
Funeral Director		5. Social Security Number 220-40-9823	6. Sex 1 □ M 2 □ F	7. Age (In yrs	s. last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bi (Month, Do Oct. 1	I, 194	9. Birth	place (State or Foreign ntry) 'ginia
and	1	Usual Residence of Decedent  10a. State 10b. County	/	10c. C	City, Town or Lo	cation							10d. Inside City Limits
Maryl 1 sho	Į	Md. Harf	ord			gewoo	hd						1 ☐ Yes 2 ☐ No
r 28a	rec	10e. Street and Number				10f. Zi					10g. Citizen	of What Cou	
th wit	aiD	2019 Armstrong	Street				21	040			Unite	d Stat	es
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental hygiene. Importent: If Item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury or other treumatic event, the Medical Examinar must be maillised at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Ziorcee	ried 1 □XYes	2 □ No ive		Was Dece If Yes, spe 1  Yes		ispanic Orion, Mexican Specity:	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)		Race - Ameri Black, White, ecity: wh	
5-0	Completed	15. Deceder	nt's Education est grade completed	)	16a. Dece	dent's Usu	al Occupa	ation	t of worki	na	16b. Kind	of Business/In	ndustry
dithin New Year	mple	Elementary/Secondary (0-12)		(1-4or 5+)	driv		se retired,	during most	OF WORK	'g	A	1 - 1 - 2	_
iled w Hygier ther ti		12 years 17. Father's Name (First, Middle,	(ast)		dilv	E1		10 Matha	ria Nama	(First, Middle		lodgin	ıg
d be if	o Be	Victor V. Stan	,									name;	
Shoul nd Me mark	<sup>L</sup>	19a. Informant's Name/Relations			19b. Maili	ng Address	s (Street a			. Comb		own. State. Zii	p Code)
Mid 2 Ind 2 Island 27 Isla		Betty J. McGui	re/sister	•						, Edge			
Ore,		20a. Method of Disposition	2 Dam   fram		Place of Dispo	sition (Na	me of			ate		on - City or To	
altimore, mit. Pages 1 ar partment of Hee portent: If Item y Injury or othe		1 ☑ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (5		Ga	ardens				5/27	/2004	Balti	more,	Md.
Ball permit. Depart Import any inj once.		21. Signature of Funeral Service	1 0 0		1	Schi	mune	k Fun	eral	Home	of Bel	Air,	
Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	r complications that t only one cause on	caused the dea	ath. Do not ent	er the mos	de of dying	g, such as	cardiac o	r respiratory	vrest, All	, Mu.	21014 Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):			200					
LAGITITIO	<u></u>	Sequentially list conditions, if any, leading to immediate	b. ———	(or as a conse	auanaa afti								
nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	<	(or as a conse	squence or,								
execu nn and ial-tra	Exa	that initiated events resulting in death) Last	C. Due to	(or as a conse	equence of);								
58760, licate be executed physician and s the burial-transit	dicai		d										
	Ψ.	IF FEMALE:											
Records, P.O. Box 6: The law requires that the death certific tile has been signed by the ettending p bage 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregr birth 2 ☐ Fel nant at time of nown	tal death 3	Ectopic pi Other (sp					23d.	Date of delive Month	ery Day Year
S, P	by PI	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did t	obacco use o	contribute to the	he cause of death?
Cords w require been sig	edt	tripped	na							×	Yes 2□N	o 3∏Prob	pably 4 □Unknown
ecc law re as be 2 sho	Completed	10								24a. Was		4b. Were auto	ppsy findings available impletion of cause of
	Соп										ormed?	death?	2 No
NY VITAI REC hysician: The law his certificate has b I director, page 2 s	Be	25. Was case referred to medica examiner?	Hospital:				0.1		of Death	(Check only o	one)	/ )	
Ing P	lon; To	1  Yes 2 No  27. Manner of Death Natural 5 Pendir	28a. Date (Mor	Inpatient 2X of Injury oth, Day Year)	28b. Time of Injury	2	28c. Injury Work	at	2	ne 5 Resi			(y)
VISIO	ficat	2 Accident investi	not be	e of Injury - At I	home farm str	M eet facton		/es 2 □N		8f. Location (	Street and No	imber or Rum	al Route Number.
DIVISIO DIVISIO A Hospital or Attend 24 hours after death e Funeral Director: /	Certification;	4   Hornicide	build	ling, etc. (Spec	eify)					City or To	wn, State)		
	Medical	29a. Certifier 1 Certifyii (Check only 2 Medicel	ng Physician: To th Examiner: On the t and mar	e best of my kn pasis of examin nner stated.	nowledge, death nation and/or in	occurred estigation	at the tim i, in my op	e, date and pinion, deat	n place, a th occurre	nd due to the dat the time,	date and pla	manner as si ce, and due to	tated. the cause(s)
within To the comple	Me	29b. Signature and title of certifie				290	c. License	number			29d. Date sig	gned (Month,	Day, Year)
. (		1 1/ Ce	rfemi	)			O.C.	M.E			MAY	24, 2	2004
COM		30. Name and address of person	who completed cau	se of death (Ite	am 23a) (Type, 111 Per	Print)	reet.	, Bali	timor	œ. Mar	vland		
Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sign	nature					~,	Jana	-1601	
Registr	ar ·	MAY 2 6	2004	Leaver	19	Kn	a. V.	, -					

			For State Registrar	State of	r Marylan	-	artment of <i>rtificate of</i>		d Mental Hy	- 0.0	04	1677
	= 16.		1. Decedent's Name (First, Middle, La	st)					2. Date of De. Month		Year	3. Time of Death
	Physici /Medio		Elsie M. Supik	2					May		004	11:15 P
	Examir		4a. Facility Name (If not institution, give Renaissance Gard			est	4b. City, Town,	or Location of De	eath	4c. County	of Death timo)	
	Funeral Director		5. Social Security Number 6. S		7. Age (In yrs. 91		If Under 1 Year Months Days		in. B. Date of Bird (Month, Da	h y, Year)	9. Birthi	plece (State or Foreig
E.	D		Usual Residence of Decedent						766. 0	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
X	ath with the Maryland \$ 23a or 28a-f show wat be notified at	2	10a. State 10b. County		10c. Cit	ty, Town or Lo		<b>.</b> .				10d. Inside City Limit: 1⊈ Yes 2 □ No
SUPIK	the M	Director	Maryland N/A  10e. Street and Number				Baltimo/	re		10g. Citizen of V	What Cou	
5	death with the ms 23a or 28a	D	3805 Juniper F	Road			101. 2.0 0000	212	1	u.s		,
11	8 E E	Funeral	11. Marital Status	12. Was Dece	edent Ever in U	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin?	(Specify Yes or No	- 14. Rac		can Indian,
6 EUSIE 21215-0036	72 hours after	þ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or D	2 <b>X</b> No ′θ		1 ☐ Yes 2 🂢 No		iono moan, oto.,	1	who	
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gra			16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	ipation a during most of v	working	16b. Kind of Bu	ısiness/In	dustry
20 12	within ane. then	mpl	Elementary/Secondary (0-12)  10th Grade	College (1	-4or 5+)		DO NOT use retir Omemaker	ed)		Ow	n Hon	n <i>o</i>
- C	filed with Hygiene other the	Be Co	17. Father's Name (First, Middle, Last	)			manacee	18. Mother's N	Name (First, Middle,			
lan de	2 should be filed within and Mental Hygiene. is marked other than aurwatic event, the M	To B	John Svec					Fra	nces	Skrivan		
122/04 11	カモトラ	ľ	19a. Informant's Name/Relationship ( Mr. Charles W. St		son)		-		Aural Route Number altimore,		State, Zip 218	Code)
	s 1 an f Heal ftem 2 other		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other pla		Date	20c. Location -	City or To	own, State
1/5	Pages nent of int: If it		1 ☐ Burial 2 💢 Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Special	]Removal from : fy)	State		Crematori		24/2004	Baltimo,	re, M	laryland
5/32	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other QDCs.		21. Signature of Funeral Service Lice	nsee					chimunek Baltimor		Home 21236	
8760	Physician and physician and physician and physician and physician and the prival-transit	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	or as a consequence or a consequence or a consequence or a consequ	Quence of):	er the mode of dy	ing, such as card	diac or respiratory and	rrest,		Approximate Interval Between Onset and Death
Box 6	eath certifi attending   for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4⊟Pregn 9⊟Unkno	inth 2 Feta ant at time of d	ldeath 3[ leath 5[	Ectopic pregnand Other (specify)			Мо		Day Year
v.	ires that signed at be de	by	Part II. Other significant conditions	TT ( )	ath but not res	the J	nderlying cause g	iven in Part I.			nbute to ti	he cause of death?
COL	w requir been s	Completed	CHE HA	-0)	10.		11010		24a. Was		Vere auto	opsy findings available
Be	The lav	omp	, H	110					autop perfo	med?	rior to co leath?	mpletion of cause of
<u>e</u>	icien: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place of E	1  Yes Death (Check only o		10S	2
> >	hysicie this cert	To	examiner? 1 Yes 25 No	Hospital: 1 🔲 I	npatient 2	ER/Outpatier	IT 3LI DOA		Home 5 ☐ Resid	dence 6 Oth	er (Specif	у)
u C	ding Ph h. After th funeral	ion:	27. Menner of Death  1. Natural 5 Pending	,	of Injury th, Day Year)	28b. Time o Injury	Wo	ork?	28d. Describe h	now injury occurr	ed	
Division of Vital Records. P.O.	To the Aspitel or Attending Physicien: within 24 hours alter death. To the Fundral Director: After this certifica completely filled in by the funeral director.	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place	of Injury - At he	ome, farm, sti	M 1 [	Yes 2 No	28f. Location (S City or Tow	Street and Numb vn, State)	er or Rura	al Route Number,
1	Rospitel or 4 hours afte Funeral Dir tely filled in	cai Ce	29a. Certifier 1 Certifying Pl	nysician: To the	best of my kno	owiedge, deat	h occurred at the t	time, date and pla	ace, and due to the occurred at the time,	cause(s) and ma	nner as s	tated.
10	To the Mithin 24	Medical	one)	and man	ner stated.			ise number				
	T Will		29b. Signature and title of certifier	1	0		D	5311r		29d. Date signed  May 2	60	2007
	IV		30. Name and address of person who	completed caus	FOO (	п 23a) (Турө, va lth	Print) P(~)	Park	will m	0 212	57	
	Sta	ate	31. Date filed (Month, Day, Year)		egistrar's Signa							

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

			For State Registrar	State of Maryla		artment of h			iene <sub>eg. No.</sub> 2004	16779
* * * * * * * * * * * * * * * * * * *	Physici		1. Decedent's Name (First, Middle, Last) CHARLES	W.	SCONES			2. Date of Dear Month May 24	Day Yeer	3. Time of Death 9:40 P M
	/Medio Examin Funeral Director		Mariner Health of S. Social Security Number 6. Sex 115-09-3948	f Glen Burn	rs. last birthday)	-	Burnie If Under 24 Hr:	8. Date of Birth	, Year) Coi	u ndel u ndel hplace (State or Foreign untry) Vland
15		or	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arun	10c.	City, Town or Lo			OCC. 27	,1500 Hai	10d. Inside City Limits 1 □ Yes 2 No
vith the M	or 28a-f	Direct	10e. Street and Number	dei	1 asade	10f. Zip Code		1	10g. Citizen of What Co	
1215-0036 within 72 hours after death with the Maryland	ut of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Wedtsel Examinet main be mailfied at	by Funeral Director	818 207th Street  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1  Yes 2 W No lf Yes, Give Year or Dates:				Specify Yes or No- rto Rican, etc.)	U.S.A  14. Race - Ame Black, White  Specify: Whi	rican Indian, e, etc.
Maryland 21215-0036 ad 2 should be filed within 72 hours aft	ene. than *natura tin Wedical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occup kind of work done DO NOT use retire gine Med	during most of we	orking	16b. Kind of Business/Curtis Mot	
land 2	Mental Hygiene. arked other tha atic event, the	To Be Co	17. Father's Name (First, Middle, Last)  George T. Scones			<u> </u>	18. Mother's Na	R. Shiel		
Maryla nd 2 should	eaith and M m 27 is mai her traumai		19a. Informant's Name/Relationship (Type Anna R. Bohuslav	, Print) (Daughter)					r, City or Town, State, 2 aryland 211	
ore,	ent of Hea nt: If item ry or other		20a. Method of Disposition  1. Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	moval from State	b. Place of Dispo cemetery, cre	CHICAGO CONTRACTOR	ice)	Date	20c. Location - City or	
Baltimo	Department of Important: If it any injury or one		21. Signature of Funeral Service Licenses		1 /2	2. Name and Addre	ess of Facility	4. 7		
8760, ate be executed $\overline{\mathbf{U}} \leq$	hysician and hysician and hysician hysician hysician and hysician stransit	dical Examiner	shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a con	requence of):  Ven Size  asequence of):  clac	'ardio e Car Carra	myo for Lives ythen	sathy	isease	Interval Between Onset and Death Many Gens
O. Box 6 the death certific	the attending thed for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 \( \subseteq No \) 9 \( \subseteq Unknown \)	c. If yes, outcome of pre 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetel death 3	□Ectopic pregnand □ Other (specify) _	y		23d. Date of deli Month	ivery Day Year
o E	gu	þ	Part II. Other significant conditions cont	ributing to death but not	t resulting in the t	inderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
Rec	cate has been si , page 2 should	Completed							sy prior to death? 2⊠No 1 □ Yes	utopsy findings available completion of cause of
Sing Bill	leath. tor: After this certificate the funeral director, pac	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 28c. Inju	her: 4 Nursing		ence 6 □Other (Spec ow injury occurred	cify)
Division el or Attending	24 hours after death. 9 Funeral Director: A 9tely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, st	reet, factory, office		28f. Location (S City or Town	treet and Number or Ru n, State)	ıral Route Number,
Hospitel	within 24 hours after d To the Funeral Direct completely filled in by	edical (		ician: To the best of my er: On the basis of exam and manner stated.						
To the	within 2 To the complet	Me	29b. Signature and title of certifier		40	29c. Licen	se number (	7	29d. Date signed (Month	n, Day, Year)
	1		30. Name and address of person who cou		(Item 23a) (Type	Print)	ark, a	elen Bul	oria, Mn.	,
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 6 7004	32. Registrar's S	Signature	low v.		-	5. 25 one, Mn.	

ORIGINAL

		1	For State Registrar	State o	f Maryland		artment of tificate o			Reg. N	2001	16780
	Physicia /Medic	n	1. Decedent's Name (First, M. Dennis	<sub>ddle, Last)</sub> Jerome	Smallwo	od				ate of Death Jonth 24	ay 2004 <sup>ear</sup>	3. Time of Death 2:05 AM
}	Examin	er	4a. Facility Name (If not institu ANNE ARUNDEI	MEDICAL	CENTER	* 6 int	4b. City, Town ANNAF	OLIS			c. County of Death	NDEL
	Funeral Director	4	5. Social Security Number 212-58-7722 Usual Residence of Decedent	6. Sex 19⊠ M 2□ F	7. Age (In yrs. las	Yrs.	Months Day		Min. Oct	fonth, Day, Yea.	53 MARY	place (State or Foreign ntry) "LAND
	Maryland i show		10a. State 10b. Cou		10c. City, 1	_	cation					10d. Inside City Limits 1 ☐ Yes 2 In No
:	with the	Direc	10e. Street and Number			0110	10f. Zip Code				Citizen of What Cou	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours affer death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I marked other then "naturel", or items 23e or 28e-f show importents: I fiem 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other traumatic event, Ite Medical Examinat must be redifficat at once.	by Funeral	1569 Lodge Pol  11. Marital Status  1 □ Never Married 2 □ I  3 □ Widowed 4 ☑ Divor	12. Was Dec Armed Fo Married 1 ☐ Yes If Yes. Gi	2 <b>⊠</b> No ⁄e		Was Decedent of the Yes, specify Co		igin? (Specify ` n, Puerto Ricar	res or No-	USA 14. Race - Ameri Black, White, Specify: Whi	, etc.
21215-0036	vifhin 72 hou ne. hen "naturel e Medical E.	Completed	15. Dece (Specify only hi Elementary/Secondary (0-1	dent's Education phest grade completed)  College (	1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during mos ired)	st of working		Kind of Business/lr	
C	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Ita Mis	Be	10 17. Father's Name (First, Mid Louis A.	Smallwood			rorema	18. Moth		it, Middle, Maide	an Sumame)	pe Co.
<u>a</u>	d 2 should I th and Meni t7 Is market traumatic	욘	19a. Informant's Name/Relat Elizabeth					et and Numb	er or Rural Rou	ite Number, City	or Town, State, Zi, s. Maryla	
Je,	Pages 1 and 3 nent of Health out: If item 27 ury or other tra	Ì	20a. Method of Disposition  1	on 3 Removal from	State 20b. Plac	e of Disponentery, crea	osition (Name of matory or other p	nlace)	Date	20c.	Location - City or T	own, State
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Fun sees	rice Licensee	min	2	Name and Ado Cully-P 204 Moun	dress of Facili	ity			
,092	Medical afternation of the control o	dical Examiner	ingediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Jesue or nur that initiated events resulting in death) Last	b	(or as a conseque)	nce of):	lept	(-)				
.O. Box 68	that the death certifica ed by the affending ph detached for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live I	tcome of pregnanc birth 2 □ Fetal di nant at time of dea own	eath 3[	□Ectopic pregna □ Other (specify)				23d. Date of deliv Month	rery Day Year
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant cor	ditions contributing to d	eath but not resulti	ing in the u	nderlying cause	given in Part	t.    :	•	\ /	the cause of death? bably 4 □Unknown
Ä	The law ate has b bage 2 s	Completed								24a. Was an autopsy performed?  Yes 2	24b. Were autroprior to codeath?	opsy findings available ompletion of cause of
of Vital	Physicien: Th r this certificate ral director, pag	To Be	25. Was case referred to me examiner?  1 Yes 27 No.  27. Manner of Leath	Hospital:		VOutpatie	nt 3 DOA	Other: 4 🗆 N			6 □Other (Speci	ify)
Division	To the Hospitel or Attending Ph within 24 hours affer death. To the Funerel Director: Affer th completely filled in by the funeral	Certification;	1 Natural 5 Pe	restigation ould not be termined 28e. Place	of Injury  th, Day Year)  e of Injury - At hom ing, etc. (Specify)	Injury	M 1	njury at Vork? □Yes 2□	]No 28f. L		and Number or Rur	ral Route Number,
	he Hospit in 24 hours he Funere plefely fille	edical	29a. Certifier (Check only one)	ifying Physician: To th ical Examiner: On the t and mar	e best of my knowl pasis of examination oner stated.	ed <i>g</i> e, dea n and/or ir	th occurred at the	time, date a y opinion, de	nd place, and c ath occurred at	the time, date a	nd place, and due	to the cause(s)
)	To the To the Comp	×	29b. Signature and title after	rtifier	MD		29c. Lice	ense number	87	29d. 0	Date signed (Morth)	Day, Year)
	5		30. Name and address of pe	rson to completed cau	se of death (Item 2	23a) (Type	Print)	brand	e / 1	1edce	a Ce	yter
\$1	Sta Regist		31. Date filed (Month, Day, 1) MAY 2 6 2	1	Registrar's Signatu	le η	bach					

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ı	Physici		1. Decedent's Name (First, Middle, Las AMIE MARI				2. Date of Dea Month May	ath Day 18	2004	3. Time of Death	h M
	/Medic Examin		4a. Facility Name (If not institution, give 36 Ballyhaiunes Co		4b. City, Town, or L Luthervil				County of Death Baltimor	e	
	Funeral Director			7. Age (In yrs. last birth □ M 2∰F 30 Yı	Adversaria Description	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Sept. 0	v. Year)	9. Birthp County 73 Mary	lace (State or Fore try) 1and	ign
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Anne Arus	ndel Co. Balt	or Location				1	0d. Inside City Lim	
	h with the 3a or 28e	al Director	10e. Street and Number 414 Carvel Beach	Road	10f. Zip Code 21226				en of What Coun	itry?	
020	be filed within 72 hours after death with the Maryland tal Hygiene.  do ther than "neturel", or items 23a or 28e-f show event, the Madeal Examiner must be nutified at	by Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 1f Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🎇 No	panic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Americ Black, White, Specify: Whit	etc.	
0000-01717	hin 72 hou an "neture Modical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation 16a. D de completed) ( College (1-4or 5+)	Decedent's Usual Occupati Give kind of work done du life. DO NOT use retired)	on ring most of wor			d of Business/Inc		
V	ad wit	Con	12	0	Clerk				enience	Store	
2	tal Hydral Hydral eveni	Be	17. Father's Name (First, Middle, Last)	Cid1 ovalei	1	8. Mother's Nan Carol	ne <i>(First, Middl</i> e, M.		art		
Maryland	2 should and Men Is marke eumatic	욘	Alan A.  19a. Informant's Name/Relationship (7)		Mailing Address (Street an 14 Carvel Be	d Number or Ru	ıral Route Numbe	r, City or	Town, State, Zip		
D.	as 1 and of Health item 27 r other tr		Alan A. Sidlowsk	20b. Place of I	Disposition (Name of crematory or other place)		Date Date		ation - City or To		
ballinore,	permit. Pages Department of I Importent: If ite any Injury or of once.		1 ☐ Burial 2 ☑ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen	Bayviev	Crematory  22. Name and Address McCully-	05/	24/2004		ltimore,	Md.	
ă	Der Per		trul of	clications that caused the death. Do not one cause on each line.	3204 Mou	ntain_R	oad. Pas	adena	ne P.A. a, Md. 2	Approximate	
	Physician		ack, or heart failure. List only is ediate Cause (Final isease or condition resulting in death)	a Staphylococcus Aur	eus Sepsis					Interval Between Onset and Death	
	/Medical Examiner		resulting in assuring	Due to (or as a consequence of Acute Endocarditis	•						
	and sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of							
/e0,	e be executed rsician and e burial-transit	cal Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of	):						
P.O. Box 68	or Attending Physicien: The law requires that the death certificate ther death.  Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 1 ☐ Unknown	23c. If yes, outcome of pregnancy 1   Live birth   2   Fetal death 4   Pregnant at time of death 9   Unknown	3 □Ectopic pregnancy 5 □ Other (specify)			23	3d. Date of delive Month	ry Day Year	
	quires that n signed by uld be deta	þ	Part II. Other significant conditions c	ontributing to death but not resulting in the Intoxication	the underlying cause given	in Part I.		obacco us es 2 🗆		e cause of death? ably 4 (Thinkno	
DIVISION OF VITAL RECORDS,	ysicien: The law require is certificate has been si director, page 2 should b	Completed					24a. Was autop perfo 1X Yes		prior to cor death?	osy findings availa npletion of cause of 2 No	ble of
<u> </u>	iicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	optiont 3C DOA Other		ath (Check only o			- 1	
0	Phys this ral dir	- To	Yes 2 □ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outp	Jalient 3LI DUA	4   Nulsing r	lome 5 ☐ Resid			at scene	2
	ding I h. After funer	tlon	1 □Natural 5 □ Pending 2 □ Accident investigation	Form (Month, Day Year) Form	≱ry Work?	es 2 <b>X</b> No	Unknown				
DIVISI	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined			A		Street and yn, State) 11e, N	orballyna d	Route Namber,	
	To the Hospitel o within 24 hours at To the Funerel D completely filled in	edical C	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time for investigation, in my opin	, date and place nion, death occu	, and due to the orred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s)	
	To th within To the	Me	29b. Signature and title of certifier		29c. License	number		29d. Date	signed (Month, I	Day, Year)	
			30 Name and address of perspn who	enul - Kule completed cause of death (Item 23a) (T	ype, Print)	.C.M.E.			19, 200		
			PATRICIA ATO  31. Date filed (Month, Day, Year)	327 Registrar's Signature	111 Penn St	reet, Ba	altimore	, Mar	yland 2	1201	
	Sta Regist	atę rar	MAY 9 6 200	A Samuel A	Anaste)						

			For Stete Registrar	State of Ma		epartment of I Certificate of			ene g. No. 20	04	16782
	Physici	an	1. Decedent's Name (First, Middle, Last) Betty			Taylo		2. Date of Death Month	Day	Year <b>004</b>	3. Time of Death 03: 13 PM
	/Medic Examin		4a. Facility Name (It not institution, give to Johns Hopkins Bay		ed. Ctr.	4b. City, Town,	or Location of Deat	h	4c. County		<u> </u>
	Funeral Director		5. Social Security Number 6. Sec. 219–28–1666		e (In yrs. last birtho 70 Yr	Months   Days		8. Date of Birth (Month, Day, Aug. 17,	1933	9. Birthp Cour Vir	place (State or Foreign ntry) Jinia
	Maryland f show	lor	Usual Residence of Decedent  10a. State 10b. County  Maryland Harford		10c. City, Town o	or Location				1	0d. Inside City Limits 1 ☐ Yes 2√2√No
	with the I te or 28e-	Direc	10e. Street and Number 2606 Clayton Road	14		10f. Zip Code 21085	5		Og. Citizen of V	What Cour	ntry?
36	J within 72 hours after death with the Maryland jione Than "neturel", or items 23e or 28e-f show I'le Medical Estandrier must be mailified at	by Funerai		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (S an, Mexican, Puer		14. Rac	ck, White,	
21215-0036	within ene. then "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			ecedent's Usual Occu Sive kind of work done fe. DO NOT use retire	during most of wo.	rking	Restaur		dustry
Maryland 2	be filed stal Hyg stal othe event,	3e	17. Father's Name (First, Middle, Last)  John Meehan				18. Mother's Nar Hazel S	me (First, Middle, M hotwell	faiden Suman	10)	
	s 1 and 2 should f Health and Men item 27 is marke other treumetic	0	19a. Informant's Name/Relationship (Ty Faithe Taylor (Daug			Mailing Address (Stree					
Baltimore,			20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	lemoval from State	cemetery,	isposition (Name of crematory or other place of the place			20c. Location - Elen Bu		
Balti	permit. Page Deportment of Importent: If any injury or		21. Signature of European Service Commo	ee <u> </u>		22. Name and Addr Bi 1407 Old	ess of Facility ruzdzinsk Eastern	i Funeral Avenue, B	Home,	P.A. Mary	land 21221
	Physician /Medical		23a. Part1. Exter the disease, or compl shock or heart failure. List only of Immediate Cause (Final disease/or condition resulting in death)	ne cause on each li	the death. Do not ne.  Holic a consequence of)	enter the mode of dy	ing, such as cardia	c or respiratory arre			Approximate Interval Between Onset and Death 3 days
8760,	Tay requires that the death certificate be executed as been signed by the attending physician and a should be detached for use as the burial-transit	icai Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as	to nitis	deficile	colit	Hs			zdrys 3 days
.O. Box 68	it the death certifica by the attending place tached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ży			te of delive	ery Day Year
Δ.	juires that the signed by ald be detacted.	by	Part II. Other significant conditions co	ntributing to death b	out not resulting in t	he underlying cause g	ven in Part I.		acco use cont	ribute to ti	he cause of death?
I Records,	The ate h page	Completed						24a. Was ar autops perform 1 \( \text{Yes} \) 2	ned?	Were auto prior to co death? 1  Yes	psy findings available impletion of cause of 2 No
f Vital	yslcien: is certific director,	To Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	Hospital: 1XInpatie	ent 2 ER/Outp	atient 3□ DOA O	hac	ath <i>(Check only one</i> Home 5□ Reside		er (Specif	y)
Division of	ding After fune	Certification:	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	y Year) Inji	ury Wo	ork? ]Yes 2∏No	28d. Describe ho			/S
Divi	Dirte		4 Homicide determined	building, et	c. (Specify)	n, street, factory, office		28f. Location (Str. City or Town	, State)		
	To the Hospital within 24 hours a To the Funerel I completely filled	ledicai	(Check only 2 Medicel Exemi		of examination and/	death occurred at the tor investigation, in my	opinion, death occi	urred at the time, da	ate and place,	and due to	o the cause(s)
)	with To	Σ	29b. Signature and title of certifier Llopou	6. M	D		se number RES - 00		od. Date signer		
4	Z		30. Name and address of person who con Leonid Klopouh	ompleted cause of o	death (Item 23a) (T	ype, Print) astern Av	enue B	altimore	e MD	21	1224
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 6 200	32. Registr	rar's Signature	4 Some	,		-		

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Emden Carolyn Tine 2:00 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rose IIMORE tospila SQUARE d4/e If Under 24 Hrs 8. Date of Birth If Under 1 Year 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. <sup>a</sup>1914 215 68 2872 1 M & F 89 Baltimore, Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 271s marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, it a Madical Examinar must be notified at once. 1 ☐ Yes 2 No Baltimore Baltimore County Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 123 Linhigh Avenue 21236 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping-Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maxamillion Reiner Roehre Emma Ponte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary R Tine Bel Air, Md. 21014 (son) 1033 Alexandria Way Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State St Peter Luth. Ch Cem May 25 2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Lassabn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER LUNG /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 1 ☐ Yes 2 ☐ No ours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

To the Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

KIRMAN

31. Date filed (Month, Day, Year) MAY 2 6 2004

FRANKliN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

SQUARE DR

29d. Date signed (Month, Day, Year)

BAITIMORE Md 21237

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_				iai yiai	•	rtificate of			Reg. No. 2	204	16781
Н	Physici	an	Decedent's Name (First, Middle,	Last)					2. Date of De Month	Day	Year	3. Time of Death
1	/Medi	al	Dorothy		Wal	sh		45 Otto Tarres a	May 23 r Location of Deat			8:00 AM
	Examir	er	4a. Facility Name (If not institution, g									
Н			Waldorf Health  5. Social Security Number 6			last birthday	If Under 1 Year	Waldor		Char		lane (Ot to a Familia
	<sub>c</sub> Funeral Director		082-01-9731 Usual Residence of Decedent	1□ M 20 F	85	Yrs.	Months Days		n. (Month, D	iy, Year) 8, 1918	New .	lace (State or Foreign itry) Jersey
	ith with the Maryland 23a or 28a-f show ust be notified at	'n	10a. State 10b. County		10c. Cit	ty, Town or L	ocation				1	0d. Inside City Limits 1   Yes 2   No
	tha M	ectc	NJ Monmout  10e. Street end Number	:h	Ke;	yport	101 7: 0 . 1			40 000 41		
	with a	ä					10f. Zip Code			10g. Citizen of	what Coun	itry?
	s 23a	erai	50 Beers Street	12. Was Deceden	Ever in U	S 12	07735	Hispania Origin? (	Specify Ven or N	U.S.A	e - Americ	an Indian
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than *natural', or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	Armed Forces	? No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		orto Rican, etc.)	Specify	ck, White,	etc.
0	2 ho	te g	15. Decedent's (Specify only highest g	Educetion		16a. Dece	dent's Usual Occu	pation	- 4.2	16b. Kind of B		
21	ithin 7 ie.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retire		orking			
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E D	be fit d off even	Be	17. Father's Name (First, Middle, La	st)					ame (First, Middle		10)	
3	Mer Marka Marka	ပ	James Lundy					,	(Unknown)			
Maryland	d2st		19a. Informant's Name/Relationship				ng Address (Stree					•
e,	1 and Haalt em 2		Robert Walsh (S	σπ)	20b. F		Chiacamu osition (Name of matory or other pla		Date	Head, M		
Baltimore,	agas ent of t: If It y or c		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec						E /27/0/		•	, 5.2.0
#	artme ortan Injur		21. Signature of Funeral Service Lice		St.		h's Ceme		3/2//04	Keyport	, NJ	
ä	Dep Imp		) Hamis	0.14	121	_ ] ]	Day Funer	al Home		07705		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the deat	h. Do not en	361 Maple	PI., Ke	eyport, [ ac or respiratory a	NJ () / / 35 rrest.	1	Approximate
4	Physician	: 0	shock, or heart failure. List on	ly one cause on each I	ine.			-		·	i	Interval Between Onset and Death
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	rificata ba executed ng physician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate		Due to (o	rasa curisi	quence of).					
60,	ba e) ician buria	aj E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C								
68760,	icata phys s the	edic	that initiated events resulting in death) Last		Due to (o	r as a consec	juence of):				į	
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Box	d for	cia	Part II. Other significent conditions	contributing to death h	out not rock	ulting in the u	ndodvina sauso ais	on in Rost I	22h Did	tohonno uno non	atributa ta	the cause of death?
P.0	that the daath cer ed by the attendir datached for use	hys	ran II. Other significent conditions	contributing to death t	ALTHOUTES!	uiting in the u	ilderlying cause gi	von in rait i.		Yes 2□ No		ably 4 Unknown
	s tha	by P					4					, /
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be datached for use as the burial-transit	Completed								an autopsy rmed?	ava con	re autopsy findings ilable prior to npletion of cause leath?
<b>E</b>	Tha ata hi paga	Son							1000	165 25X110	10	lYes 2□110
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Division	or Attandi after death. Director: A i in by the fi	Certification:	4 ☐ Homicide determine	building, et			eet, factory, office		City or To	Street and Numb vn, State)	er or Hurai	Houte Number,
_	To the Hospital or Attanding Physician: Tha I within 24 hours after death.  To the Funeral Director: After this cartificata he complately filled in by the funeral director, paga	edical C	29a. Certifier (Check only one)  Certifying F  2 Medical Exception	Physicien: To the best pminer: On the basis o and manner st	of my know	wledge, death tion and/or in	n occurred at the til vestigation, in my o	me, date and piace pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)
	o the	Med	29b. Signature and title of tertifier	and mailler st	atou.		29c. Licens	e number		29d. Date signed	d (Month, E	Day, Year)
	F \$ F 0		AMA				112	1248		24 An.	())	Och
	1	-	30. Name and address of person who	completed cause of o	leath (Item	23a) (Type	Print)	() ) ()		A 1 1 1	10	004
	7	4,	31. Date filed (Month, Day, Year)	€ MO 32. Registr	5mi	te 10	. 1	Line	Onter	halde	irt, 1	M 2060
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DHMH 16 Rev 6/95

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MAN		1-	For State <b>Unpend</b> Registrar	Item	#23a,27,	28a-f,	PER ME	tificate of	Death			004	16785	
Phys	ician		ecedent's Name (Fin	_				2. Date of Death Month				4 Year	3. Time of Death	
	dical			innah		Faith		Williams				4 unty of Death	0525 A M	
Examiner  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death							40.00	uniy or Death						
Funor	Johns Hopkins Hospital  5. Social Security Number 6. Sex 7. Age (In )							If Under 1 Year	If Under 24		Birth	9. Birth	place (State or Foreign	
Director 228-93-5720 1					1□ M 2\ F	M 2 F 2 Yrs.			onths Days Hours Min. (Month, Day, May 8,			Year) Country) 2002 Virginia		
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d.									10d. Inside City Limits			
Maryl f sho	į	WV Hampshire Shanks									1 □ Yes 2 ₩ No			
r 286	9	10e.	10e. Street and Number							10g. Citizen	of What Cou	ntry?		
th witt	<u> </u>	H	HC 78 Box 42BB						1	USA				
r dea	Funeral Director	11.1	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?						Hispanic Origin an, Mexican, P	No- 14.	Race - Amer Black, White			
Maryiand Z I Z I 3-UU30 Ind 2 should be filed within 72 hours after death with the Maryland Int and Mental Hygiene. Z7 is marked other than "naturel", or Items 23a or 28e-f show recumatic event, the Medical Evant are must be anotified at	2	3	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						Specify:		Specify: White			
72 h 72 h "natu	Completed		15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give						pation during most of ed)	16b. Kind	of Business/Ir	ndustry		
d Z I Z filed within Hygiene. ither than	1 8	E	Elementary/Secondary (0-12)  none  College (1-4or 5+)  none						none					
filed Hygin other	0	17.	Father's Name (First	, Middle, La	ast)				18. Mother's	Name (First, Midd	die, Maiden Su	mame)		
	L C		oger Lee	Willi	ams, Jr				Shilo	h Renee	Aumock			
2 should and Men Is marke	Ι.		. Informant's Name/I	Relationship	p (Type, Print)	(Fathe	r) 19b. Maili	ng Address (Street	t and Number o	r Rural Route Nur	nber, City or To	wn, State, Zi	p Code)	
		-	oger Lee		ams, Jr.			Lee Bur	ke Road	Front	Royal,	VA 22		
Saltimore, Dermit. Pages 1 al Department of Hee mportant: If Item any Injury or othe	Ш	20a.	Method of Dispositi 1 ☐ Burial 2 ☐ Cre		B □Removal fron	State	cemetery, cre	matory or other pla	1			•		
ILIM it. Pa rtmen rtant: njury		3.	'4 □Donation 5 □Other (Specify) Prospect Hill Cem. 5-21-04 Front Royal, VA											
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	-	23	23a. Pav1. Erter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
/ / / / / / / / / / / / / / / / / / /	Interesting in death)  Itemediate dause (Final Issass or condition resulting in death)  a. Head Injuries  Due to (or as a consequence of):									Onset and Death				
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S, F. 6 es thet the gned by be detact			Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.							d tobacco use	co use contribute to the cause of death?			
rdS, quires n sign ald be	7									1[	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknow			
	Completed	_								24a. W au pe 1 X Yes	itopsy informed?	4b. Were autoprior to condeath?	opsy findings available ompletion of cause of	
Of VICAL Physicien: T this certificat ral director, pa	a	25.	25. Was case referred to medical axaminer?  Hospital:  Other											
Phys this al di	٢		1 X Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death  28a. Date of Injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred									fy)		
	100	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28b. Injury at Work? 28d. Describe how injury occurred Unknown 28d. Describe how injury occurred 1 \( \text{No} \) 28d. Describe how injury occurred 1 \( \text{No} \) 28d. Describe how injury occurred 1 \( \text{No} \) 28d. Describe how injury occurred 28d. Describe how injury occurred 38d. Describe how injury occurred								ed				
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To a grant and a state of the s									unknown					
To the Hospital within 24 hours a To the Funeral I completely filled	Modical		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
To the withing To the comp	M	298	. Signature and title	of certifier	\	00	000	29c. Licen	se number		29d. Date s	igned (Month,	Day, Year)	
			Hatu	ران	lioni	en collabora O.C.M.E.					May 2004			
		39	Name and address	of person w	no completed ca	se of death (I				D 11.			1001	
B.	State	.31.	Date filed (Month, D	Day, Year)	MICK-1	Registrar's Sig		renn S	reet,	Baltimor	e, Mary	land 2	1501	

State Registrar

DHMH 17 Rev 1/2001

MAY 2 6 2004

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 16786 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>004</u> Year **Physician** May 20, Richard Dennison Wooster 8:44 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 2 M 2 ☐ F **Funeral** Hours Days Months 11-5-1944 578-58-8896 59 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City. Town or Location 10a. State 10b. County ral, or items 23e or 28e-f ehow Examiner must be notified at 1 Yes 2 No Maryland Anne Arundel Annapolis Direct with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21401 Funeral 333 Epping Way death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1966–69 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry The Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12th Hardware Store Manager other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I Donald William Wooster Charlotte Arletta Sheads 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If item 27 is
eny injury or other trau Ellen J. Wooster/ Wife 333 Epping Way, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Donation 5 ☐ Other (Specify) Crownsville, MD MD Veterans Cemetery | 5-25-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) d arrhy **Physician** Cal /Medical Due to (or as a consequence of): **Examiner** etastatic ronary carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) nding physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No autopsy performed? 2 No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending nours after death.

neral Director: Af
filled in by the fur 1 Yes 2 No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after o the Hospital within 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10056461 30. Name and address of person who completed cause of death (Item 23a) Type. Print)

Cinctabler N. Irocke, MD Deat Porthology 22 S. Greene St, UMMC, BAGOIMD 21201 Christopher 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

MAY 26 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) WASHINGTON Month Year B. 1215PM MAMIE DE 2004 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) NURSING HOME MONTGOMERY CROSS BURTONSVILLE HOLY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 200F 578-26-908 DLO Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location MD 1 ☐ Yes 2 ☑ No HOWARD COUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6403 DRY BARLEY LANE U.S.A. 21045 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 SoNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: ACK 1 Yes 2 TNo Specify: 3 MWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) DRIVATE Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SADIE TINSLEY HENRY BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANDREW WASHINGTON LANE COLUMBIA 6403 DRY BARLEY 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \$\mathcal{B}\$Burial 2 □ Cremation 3 □ Removal from State 05 29/04 MADISON, VA MADISON MEMORIAL GARON \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES 21. Signature of Funeral Service Licenses Jangh. SISI BALTIMORE NATIONAL PIKE BALTO MD 21229 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helm failure. List only one cause on each line. Immediate Cause (Final weeks disease or condition resulting in death) Imonar Due to (or as a consequence of): 0 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery pregnant 3 Ectopic pregnancy Month Day Year onths? 4☐Pregnant at time of death 5 Other (specify) No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m eny injury or other traum once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

or Itams 23s or

other traumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Itst

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

death with the Maryland

The law requires that the death certificate be executed burial-tran attending physicien

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Examiner Physician/Medical for use as detached þ 90 page 2 should Be Completed funeral director, Medical Certification: To

Division of Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent p
in the past 12 m
in the past 12 m 1 ☐ Yes 2 💢
O Title to a come.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was	
auto	
perfe	ormed?
1 ☐ Yes	242 N

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner' 1 Yes 2 No 27. Manner of Death

5 Pending

investigation

Hospital: 1 Inpatient

3□ DOA 2 ER/Outpatient 28b. Time of Injury 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Poul at

29c. License number D4323 29d. Date signed (Month, Day, Year) May 29, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PK. Dr. #102 Laurel MP 20707

Phul Armstrone 31. Date filed (Month, Day, Year)

MAY 2 6 2004

4201 Laurel 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No.2									-2110h	16788			
			Decedent's Name (First, Middle	2. Date of D			te of Death	eath 3. Time of Death					
	Physici /Media		Richard Elliott				Wilson May				3 2004	1114 M	
	Examir		4a. Fecility Name (If not institution	n, give street and	number)		4b. City, Town	n, or Location	of Death		4c. County of Death		
			Anne Arundel				Annap	_			Anne Arundel		
	Funeral		5. Social Security Number 216–28–3615	6. Sex 12 M 2 ☐ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Ye Months Da		Min. 8. Da	te of Birth onth, Day, Ye 1. 27,	9. Birth Con	pplace (State or Foreign untry)	
	Director		Usual Residence of Decedent		/4				Jar	1. 2/,	1930 Ma	ryland	
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	ocation					10d. Inside City Limits	
36	Many 1-1 sh	ţo	MD Anne	Arundel	L (	Crownsv	ille					1 ☐ Yes 2 📉 No	
	ath with the 23a or 28a	Director	10e. Street and Number				10f. Zip Cod	9		10g.	Citizen of What Co	untry?	
		la	1578 Severn Ch					1032		USA			
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel" or Items 23e or 28e-1 show event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married	ried Armed	ecedent Ever in U Forces? es 2 □ No Give or Dates:		Was Decedent of Yes, specify C		rigin? (Specify Ye an, Puerto Rican, 7:	etc.)	14. Race - Amer Black, White Specify:		
21215-0036	72 hou	ted	15. Deceder (Specify only highe	nt's Education	ad)	16a. Dece	dent's Usual Oc kind of work do	cupation	st of working	16t	o. Kind of Business/I	ndustry	
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Z	s 1 and 2 should if Health and Menitem 27 is marketother treumatic		19a. Informant's Name/Relations			19b. Maili	ng Address (Str				ity or Town, State, Z	ip Code)	
	5 € Z € Z		Elizabeth L. V	Vilson (V	Vife)	1578	Severn	Chape1	Road, (	Crowns	ville, MD	21032	
altimore,	of Healitem		20a. Method of Disposition	0 🗆 🖰 🗆 1 (	20b.	Place of Dispo	sition (Name of matory or other	place)	Date	200	c. Location - City or 1	Town, State	
Ē	Page nent o ant: If ary or		XXBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5		JIII State I				5/26/200	)4 M:	illersvil	le, MD	
Balt	permit. Pages. Department of H Importent: If ite eny injury or of		21. Signature of Funeral Service	yicansee		22	Name and Ad Hardest 12 Ridg	dress of Faci y Fune ely Av	ral Home renue, Ar	P.A	is, MD 21	401	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications the	at caused the dea	th. Do not en	er the mode of	dying, such a	s cardiac or respi	ratory arrest,		Approximate Interval Between	
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9		Med	IF FEMALE:	-									
.O. Box		Physician/Med	23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   5   Other (specify)								23d. Date of delivery Month Day Year		
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	To the Hospital or Att within 24 hours after d To the Funerel Direct Completely filled in by	Medical C											
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	2,		30. Name and address of person	who completed of	<del>-</del> -	~	Print)	1.Am	c Av	nope	123/ey	21401	
State Registra			31. Date filed (Month, Day, Year,	2004	2. Registrar's Sign		Sou	KN		0			
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			1 State Registrar	State of Maryla	nd / Depa <i>Cen</i>	rtment of H tificate of L	ealth and Death		Reg. No.	2004	16789
	Physic /Medi		1. Decedent's Name (First, Middle, Las Sterling	"Wallace				2. Date of De Month	Day	Yeer 2004	3. Time of Death 8 40 P M
	Exami		4e. Facility Name (If not institution, give North West Ho	street and number)		4b. City, Town, or	Location of De	ath .	4c. (	County of Deeth	1
	Funeral Director		5, Social Security Number 6. Sr 36-0496		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi	s. 8. Date of Bi			nplace (State or Foreign untry)
	Maryland e-f ahow	ctor	Usual Residence of Decedent  10a. State  10b. County  Battin	nore 10c. c	City, Town or Loc	DIKESVI	11e.				10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28 ust be no	al Director	10e. Street and Number 7025 Aben Ro	xad		10f. Zip Code	28		10g. Citiz	en of What Cou	untry?
980	72 hours after death with the Maryland "natural", or Itama 23a or 28e-f ahow idical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces?  1	lf	as Decedent of His Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		4. Race - Amer Black, White Specify:	
21215-0036	d within giene. or then	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1,4or 5+)	(Give k	ent's Usual Occupa ind of work done d O NOT use retired)	uring most of w	orking	16b. Kind	d of Business/li	ndustry
Maryland	should be filed nd Mental Hygia marked other matic event, to	To Be C	17 Father's Name (First, Middle, Last) Sterling Walk	ce Se.		77'1	Dorot	ame (First, Middle,	afiel	d	
_	Health ar Health ar tem 27 ia		19a. Informant's Name/Relationship (7)  20a. Method of Disposition		7025	Address (Street a. Adden	Road,	PIKESVI Date	He n	Town, State, Zing 2000 2000 ation - City or T	1208
Baltimore,	permit. Pages Department of Importent: If I any injury or o		1 Bunal 2 Cremation 3 Company 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	KI	vs Men	Name and Address	K 5-	27-04 hughn C	Bat	timore	MO eral Service
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	Enco	the mode of dying	, such as cardia	ic or respiratory at	rest,	own, r	Approximate Interval Between Onset and Death
68760,	ificate be executed g physicien and as the burial-transit	al Examiner	Esquentially list curunions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecuence)	trach	mfect	ión				241s IMC
P.O. Box 687	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 9 \( \subseteq \text{ Unknown} \)	d	al death 3 E	ctopic pregnancy other (specify)			230	d. Date of delive	ery Day Year
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<u> </u>	sician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ISD/O	Other		ath (Check only or			
Division of	nding Phy ath. r: After this e funeral d		27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury a Work?	4 ∐ Nursing r	dome 5 Resid			y)
DIVIS	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director;	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street y)	, factory, office		28f. Location (S City or Tow	treet and M n, State)	Number or Rura	l Route Number,
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<u> </u>	Tot Total	ž	29b. Signature and title of certifier	Physici	an	29c. License r		2	9d. Date s	igned (Month, I	Day, Year)
	5		30. Name and address of person who co		n 23a) (Type, Pri	ountain	Road	Pasa der		//	21122
	Sta Registra	ie	31. Date filed (Month, Day, Year) MAY 2 6 2004	32. Registrar's Signa	ture 1	24					The state of the s

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1605M May 2°1 2004 **Physician** William Joseph White, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel 405 Doris Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11, 1947 9. Birthplece (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1**№**M 2□F 57 Maryland 219 52 8213 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show item 27 is marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Medical Exert are must be confilled at 1 Yes 2 No Baltimore Anne Arundel Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21225 U.S. 405 Doris Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status be filed within 72 hours after on the half hygiene. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) if Health and Mental Hygiene. College (1-4or 5+) E B Y Brown Company Warehouseman 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be. Department of Health and Mental Himportant: Hitem 27 is martany injury or other. Be Annie Ellis William J. White Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Doris White / Wife 405 Doris Avenue 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/25/2004 Baltimore, Maryland Bayview Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway mamuoufse part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** KUCCAYO /Medical Due to (or as a consequence of): **Examiner** teriosclerot Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day įo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No. 3 ☐ Probably 4 ☑ Inknown should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Certification: To the Hospitel or Attending 5 Pending investigation 1 Matural death. 1 Yes 2 No within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical route 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) ones, my 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 6 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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	Physici /Medic		1. Decedent's Name (First, Middle, Last)	hite, Jr.		imoute or i	304.17	2. Date of Dea Month	ath Day Year	3. Time of Death 4 3.34 P M
\$1.00 m	Examir Funeral Director		4a. Facility Name (If not institution, give st  University of Many)  5. Social Security Number  213 28 3119	treet and number)  CND MCd CC S  7. Age (In yrs. I	/stems last birthday) Yrs.	4b. City, Town, or Baltiw If Under 1 Year Months Days	Location of Death  VV  If Under 24 Hrs.  Hours Min.	8. Date of Birt (Month, Day August	4c. County of De	ath  A  inthplace (State or Foreign Sountry) Virginia
	ס		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Ma or 28a-f a be notified	Director	Maryland Anne Arur  10e. Street and Number  107 Bon Air Road		altimo	10f. Zip Code 212	25		10g. Cifizen of What C	
36	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be multised at ance.	by Funerai		2. Was Decedent Ever in U. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	'	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - An Black, Wh	
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	s 1 and 2 sho of Health and M Item 27 is ma other trauma		19a. Informant's Name/Relationship (Type William John White	/ Son	P.O.	Box 404		ena, Mar	yland 2112	3
Baltimore,	Peges 1 tment of He tent: If Iten		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ceo	emetery, crer dar Hi	sition (Name of matory or other place 11 Cemete	ry 5/27		Baltimore,	Maryland
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	e Hospita 124 hours ie Funera letely fille	edicai C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
<b>\</b>	To th within To th	Me	29b. Signature title of certifier	io Inne, N	10.	29c. Licenso			29d. Date signed (Mor	
	Ŋ		University of Mary	mpleted cause of death (Item	5/51	Print) CUS, 2	2 South	Green	May 2 e Street,	Baltimore,
	Sta Regist		31. Date filed (Mollith, Day, Year) MAY 2 6 2004	32. Registrar's Signa	ture App	ath)			,	MD. 21201

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	Physici /Medio Examin	cal	Decedent's Name (First, Middle, Las     Anna Gertrude     4a. Facility Name (If not institution, give	Yoor	)		4b. City,	Town, or	Location of		2. Date of Dea Month May	23, Day	2004 ounty of Death	3. Time of Deat 5:00 P	M
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	h the Maryland r 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City	Town or Lo	cation Balti	more						10d. Inside City Lim 1 XYes 2 □	
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900	72 hours after death with the Maryland naturel', or items 23e or 28e-1 show dicel Exercit at must be notified at	d by Funerai I	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes, Give Year or Dates:	2		f Yes, spec			Puerto Ri	ify Yes or No- can, etc.)		Black, White		_
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of	ding Ph h. After th funeral	ToB	examiner?  1 Yes 2 No  27. Manner of Death  1 Satural 5 Pending 2 Accident investigation	1 Inpatie 28a. Date of Inju (Month, Da	ry 2	R/Outpatient 8b. Time of Injury		Other Ic. Injury a Work?	4 □ Nurs	ing Home	5 X Beside	ence 6	Other (Specification)	(y)	
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ם	17. Father's Name (First, Middle,	Last)				18. Mother's Name	(First, Middle, M	faiden Sumam	96)
0	JOSEPH			YANKEI		MARY			GOLDBERG
	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Stree	and Number or Rura	al Route Number,	City or Town,	State, Zip Code)
	DOROTHY YANKEL	LOW / WIFE				OURT - PI			
	20a. Method of Disposition			ace of Dispos	ition (Name of				City or Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rag. No. 2004 Fation Ragistra MFND FIFM #10e PER FH C831 5/26/04 Gentificate of Death 2. Date of Death Month Year **Physician** 3:40 12004 ZAJDEL 23 SARA la, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Hospital Baltimore SINGI Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) POLAND 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2QF Yrs. 214-64-8612 83 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show ms 23a or 28a-f short must be notified at 1 XYes 2 No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 7015 PARK HEIGHIS AVE #B-1 21215 U.S.A. 5715 PARK HEIGHTS AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Baltimore, Maryland 21215-0036 Specify. Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) CHEF SCH00L other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WEIJC LIPSZYC HENIA CHUNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m any Injury or other traumononce. 6503 SANZO ROAD #C - BALTIMORE, MD 21209 HANNA BERKOWITZ / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) MOSES MONTEFIORE WOODMOOR 5/24/2004 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1 Filter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EdeMa Pulmonary 2 hours **Physician** /Medical Due to (or as a consequence of): **Examiner** r: tical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an 200 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 20 No : After this continue tuneral dire Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 XNatural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tittle of certifier

State Registrar

m

31. Date filed (Month, Day, Year) MAY 2 6 2004

Benjamin

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Waltefield

MD

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Hospital

2006

Baltimore

		-	1 - For State Registrar	State of Maryla	and / Depa		leaith and M	iental Hyg	-	
>	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Las     Elizabeth Ag     4a. Fecility Name (If not institution, give     1808 Millstream	nes street and number)	Ammenh	4b. City, Town, o	r Location of Death lerick		14, 2004 4c. County of D	10:00am M
	Funeral Director		Usual Residence of Decedent	□M 2X0F	rs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 4,	1912 Ne	Birthplace (State or Foreign Country) PW York
	the Marylar 28a-1 ahov	rector	Maryland Frederic		City, Town or Lo Frede			1	Og. Citizen of What	10d. Inside City Limits 1XXYes 2 □ No Country?
	be filed within 72 hours after death with the Maryland ital Hygiene.  and Hygiene.  ad other than "natural", or fleme 23a or 28a-f ahow event, fire Maufral Examination in the instiffed at	by Funeral Director	1808 Millstream Di	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	21702 lispanic Origin? (Spe an, Mexican, Puerto		U.S.A	Merican Indian,
9:00-9	2 hours afte atural', or li ical Exertin	ted by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Edit	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	140. 8	1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
Maryland 21215-0036	filed within 7. Hygiene. other then *n ent, the M. of	Completed	(Specify only highest grade Elementary/Secondary (0·12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Secr	kind of work done of DO NOT use retired	ation during most of worki		Insurance	2
ıryland	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M	To Be	Lansing J  19a. Informant's Name/Relationship (T)	Vroc		ng Address (Street	Elizabe	th	Me	ead
	1 and 3 Health Iem 27 other tr		Sandra Neander / I	Daughter 20th	1808	Millstr	eam Drive	, Freder		land 21702
Baltimore,	permit. Pages Department of I Important: If It any injury or o		1 Signature of Funeral Service Licens	P Q	estland	of Dallas	s May 20	.A. Fund	Dallas, eral Home	Texas
> 1	nysician /Medical		23a. Part I. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lications that caused the de ne cause on each line. a.	refruit	Ob East C er the mode of dyin	ig, such as cardiac o	Freder:	ick, Mary	Approximate Interval Between Onset and Death
P	sian and surial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate the line line line cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons  Due to (or as a cons  C.  Due to (or as a cons  d.	equence of):					
. Box 68	death certificat e attending phy id for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of 6 Month	delivery Day Year
rds, P.	ires tha signed d be de		Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	11.		to the cause of death?  Probably 4 Unknown
		Completed by						24a. Was a autops perform	y prior t ned?// death	autopsy findings available o completion of cause of ? es 2 \( \text{No}\)
	iding Physician: Th th. : After this certificate funeral director, pag	tlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Work	4 LI Nursing Hon	ne 5 Reside	e)  nce 6 Other (S)  w injury occurred	oecify)
Division	al or Attending s after death. if Diractor: After od in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stri cify)			28f. Location (St. City or Town	reet and Number or , State)	Rural Route Number,
	To the Mospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical (	one)	rsician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	estigation, in my of	pinion, death occurre	ed at the time, da	ate and place, and d	ue to the cause(s)
	T with	2	29b. Signature and title of certifier	Hormal	m	29c. License		29	May 14, 2	
	2		30. Name and address of person who con Joseph Ashwal, M 31. Date filed (Month, Day, Year)		as Johns		, Frederic	ck, Mary	land 2170	)2
×.	Sta Registr			6 2004 F2.		Rock	<b>.</b> 7 ·			

DHMH 17 Rev 1/2001

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			1 - State Registrar	e of Maryland		artment of He tificate of D			iene 2004	16796
	Physicia	an	Decedent's Name (First, Middle, Last)     Manufacture of the second		۸.	- 1		2. Date of Death Month	Day Year	3. Time of Death
3	/Medic	al	Muhammad Waqi  4a. Fecility Name (If not institution, give street and		Afz	4b. City, Town, or L	ocation of Death	MAY	4c. County of Deeth	004/ M
9	Examin	er		ospi tal		Cheve	4		Prince	6-erges
*	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year) 9. Birth	place (State or Foreign ntry)
ħ.	Director		232-49-5220   1 M M 2 L	F 21	TIS.			10-22-	1982   Pak	istan
	yland		10a. State 10b. County	10c. City, 1		cation				10d. Inside City Limits
	8a-fs	ecto	WV Raleigh	Beck	стеу	144 7 0 1			(111)	1 X Yes 2 No
	ath with the Marylan i 23a or 28a-f show unt be notified at		10e. Street and Number 222 Hargrove St., Ap	t#409		10f. Zip Code 25801			og. Citizen of What Cou Pakistan	ntry ?
	death	Funeral Director	11. Marital Status 12. Was I	Decedent Ever in U.S. d Forces?	13. \	Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No-	14. Race - Ameri Black, White	
36	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified.	by Fu	1 X Never Married 2 Married 1 Yes	es 2 🛣 No , Give or Dates:		I□Yes 2⊠ No		,,		sian
2-003	2 hour	ted t	15. Decedent's Education	1	16a. Deced	lent's Usual Occupati	on	1	6b. Kind of Business/Ir	ndustry
21218	rithin 7	Completed		ge (1-4or 5+)		kind of work done du DO NOT use retired) mployed	ring most of working	,9	None	
2	filed w Hygier ther tl	CO	17. Father's Name (First, Middle, Last)				8. Mother's Name	(First, Middle, N		
	e d ia b	To Be	Ch. Muhammad A	fzal			Irslat		Choudan	^ y
/lan/	ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic	9	19a. Informant's Name/Relationship (Type, Print)						City or Town, State, Zi	
	1 and Health em 27		Aquil Mirza/ cous	20b. Plac	e of Dispo	sition (Name of	D		Deckley  Oc. Location - City or T	WV 25801 own, Stete
ω E	Pages nent of ant: If it		1 ØBurial 2 ☐ Cremation 3 ☐ Removal file 4 ☐ Donation 5 ☐ Other (Specify)	rom State I		natory`or other place) Cemetery		5-04 L	ahore, Pak	istan
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signal to of Funeral Service Licensee	Mata					l Mortuar	
	70F 29		23a. Part 1. Enter the disease, or complications the	value death					Wash. D.C	. 20011 Approximate
	Physician		shock, or heart feilure. List only one cause Immediate Cause (Final	on each line.					clication	Interval Between
1	/Medical		regulting in death)	to (or as a consequer						
李藤	Examiner	<u>_</u>	Sequentially list conditions b. Due	to (or as a consequer	nce of):	*				
	uted d ansit	Examiner	Sequentially list constant if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events c.		,					
,160,	ate be executed hysician and the burial-transit			to (or as a consequer	nce of):					
6876	icate b physic s the b	edical	d							
ŏ	death certificate be executed e attending physician and ed for use as the burial-transit	Physician/Med	23b. Was decedent pregnant	, outcome of pregnanc ve birth 2 ☐ Fetal de		Ectopic pregnancy			23d. Date of deliv	
O. B.	e deat the att	/sicia	In the past 12 months/	regnant at time of deat		Other (specify)			Month	Day Year
<u>.</u>	es that the de igned by the a be detached t	/ Ph	Part II. Other significant conditions contributing	to death but not resulti	ng in the ur	nderlying cause given	in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
rds	w requires been signs should be	ed by						1 🗆 Ye	s 2⊠No 3⊟Pro	pably 4 Unknown
Records,	a 8 C	Completed						24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
a H	ysicien: The lis certificate hadirector, page							perform 1 Yes 2	⊠ No 1 ☐ Yes	2 No
Vital	ysicie s certii directo	o Be	25. Was case referred to medical examiner?  Yes 2 No  Hospital:	Inpatient 2 EF	VOutpatien	t 3 DOA Other	26. Place of Death  4 □ Nursing Hon		nce 6 ☐Other (Speci	(v)
Division of	ng Phys Uter this uneral di	on: T	1 Natural 5 Pending	Month, Day Yeer)	Bb. Time of Injury	28c. Injury a Work?		28d. Describe ho	w ipjury occurred	o STruck
isio	Attending it death.	icati	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	lace of Injury - At home	142			bridge	eet end Nymber of Run	al Route Number
<u>&gt;</u>	after I Direct	Certification:	4 Homicide determined	uilding, etc. (Specify)		Treet		City or Town,	State) Koule	rolat
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier 1 ☐ Certifying Physician: To (Check only 2 ☐ Medical Examiner: On the	he basis of examination	edge, death	occurred at the time restigation, in my opin	, date and place, a	and due to the ca	use(s) and manner as s te and place, and due t	stated.
	To the h within 2 To the F complete	Med	one) and title of certifier	manner stated.		29c. License			d. Date signed (Month,	
	2		Jalodo Al	estan 20		Hoo	55 927		May 10:	2006
	-		30. Name and address of person who completed	7 . 1/	3a) (Type,		0 11	0/	10.1	
	Sta	to	31. Date filed (Month, Day, Year)	2. Registrar's Signatur	5/11	a driv	5 0	my,	1400 14x	sd
	Regist		MAY 12 2004	Sereva	19	sparker	/			

			1 - For State Registrar		Maryland / I	Depa		t of H	ealth a		ntal Hy	giene Reg. No. 20	04 167
	hysic /Medi	cal	1. Decedent's Name (First, Middle Lucia E.	Apos	stolidis					N	Date of Dea Month May 6,	Day	3. Time of De 8:20 A
Fu	examii Ineral	ner	4a. Facility Name (If not institution Shady Grove Ad 5. Social Security Number 213–19–9794	ventist Nur	sing Home	thday)		vill	Location of e If Under 2 Hours	24 Hrs. 8	. Date of Birtl (Month, Day	Montg	Omery  B. Birthplace (State or F
	mods j.	tor	Usual Residence of Decedent  10a. State 10b. Count  Maryland Montg	y	33 10c. City, Tow					Jı	u1y 21	, 1970 W	ashington, D.
th with the	23e or 28e	al Director	10e. Street and Number 6509 Kenhowe D		Dethes	sua	10f. Zip	Code				10g. Citizen of Wh	at Country?
d 21215-0036 filled within 72 hours after deeth with the Maryland Hygiene.	uref, or items 23e or 28e-f shov al Examiner must be notified at	d by Funeral	11. Marital Status  1   Never Married 2   Ma  3   Widowed 4   Divorced	d If Yes, Give Year or Date	es? ⊠ No		Vas Deced Yes, spec			in? (Specif Puerto Ric	y Yes or No- an, etc.)	14. Race -	American Indian, White, etc.
Maryland 21215-0036 Id 2 should be filed within 72 hours aff th and Mental Hygiene.	od other than "naturel", event, It a Medical Exa	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4		(Give I life. D	ent's Usual kind of work OO NOT use None	Occupat done du retired)	tion <i>Iring m</i> ost (	of working		16b. Kind of Busin	ness/industry
<b>⊆</b> 9 ल .	marked off	To Be	17. Father's Name (First, Middle, Paul Apostolid  19a. Informant's Name/Relation:	is	10h	Mailin	n Addraga		Luz	Marce	la Sal	Maiden Sumame) ldarriga	
Baltimore, Maryla permit. Pages 1 and 2 should t Department of Heelth and Ment	any injury or other treu		Paul Apostolid  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other (S  21. Signature of Funeral Service	is/ Father 3 □Removal from Sta	20b. Place of cemeter, Mon Cremat	Dispos y, crem tgoi orii	Whea sition (Name atory or oth mery um, I Name and	tfie e of ner place, nc. Address	1d Te	Date ay 8, 004 Rober	Gait	20c. Location - Cit	, MD 20879
/Med Exam physician and	dical niner	dical Examiner	23a. Fart. Enter the disease, or shock, or lead failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Gastr Due to (or b. Due to (or	M00689 sed the death. Do n h line.  ic Cancer as a consequence of as a consequence of	ot ente	r the mode	da, I	Mary L	and 2	0814-3	3501 est,	Approximate Interval Between Onset and Deat 6 months
ath certifi	rached for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		2 Fetal death at time of death	3 🗆 E	ctopic preg Other (spec	nancy hity)				23d. Date of Month	delivery Day Year
equires that	pe	by	Part II. Other significant condition	ons contributing to death	but not resulting in	the und	lerlying cau	se given	in Part I.				e to the cause of death
The law ate has b	page 2	e Completed	25. Was case referred to medical									ed? prior death	a autopsy findings availa to completion of cause n? /es 2 \sum No
ling Phys	funeral di	To B	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pendin  2  Accident investig  3 Suicide 6 Could r	ation	jury 28b. Tir Day Year) Inji	ne of ury	28c	Other: Injury at Work?	4 <b>≰</b> Nursir	ng Home 28d.	Describe how	nce 6 □Other (S v injury occurred	
o te	etely filled in by	S E	4 Homicide determine  29a. Certifier  (Check only 2 Medical I	Physicien: To the bes	njury - At home, farmetc. (Specify)	death o	coursed at	the time	date and pl	1000 000	Dity or Town,	State)	Rural Route Number, as stated.
To the Hospital within 24 hours a To the Funeral I	complete		29b. Signature and title of certifier	and manner	stated.	or inves	29c. L D2	my opini icense ni 8656	on, death o	occurred at	the time, dat	e and place, and d d. Date signed (Mc lay 6, 20	onth, Day, Year)
Re	State gistra	e <sup>3</sup>	Ravi Passi, M.I	). 8609 Sec		e, 7				Sprin	g, MD	20910-33	74

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			For	State of Ma		artment of Hea		ental Hyg		0.1
			1 - State Registrar		Cei	rtificate of De	eath	Re	ig. No. 20	U4 16791
			1. Decedent's Name (First, Middle, Last)		-			2. Date of Deat Month		3. Time of Death
	Physici /Medic		WANEDA	PEARL	BA	KER		MAY	10 200	
>	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Lo	cation of Death		4c. County of	Death
*			WILSON HEALTH CA	RE CENTER		GAITHERS	BURG		MONTO	OMERY
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		214 07 5438	M 2 <b>X</b> F	95 Yrs.	Months Cays	IVIAI.	May 9	1909	Maryland
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					40d Inside Challings
	aryla ehov	_		101014		cation				10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-1	cto	Md. Montgom	ier y	01 ne y					
	ith th	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of Wha	·
	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f ehow the Moulcel Estabilier mast ke notified at	S.	17537 Queen Eliz				0832		United S	
	er de	Funerai	T. Maria States	12. Was Decedent E Armed Forces?		Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, White, etc.
36	s afte	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐ Yes 2 ☐ ♣N	•	1 ☐ Yes 2 █ <b>c</b> No S	Specify:		Specify:	White
21215-0036	hour urel	d b		Year or Dates:	16a Daga	dont's House Convention			ICh Kind of Dunio	
<u> </u>	n 72	iete	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupation kind of work done durit DO NOT use retired)	ng most of working	ng	16b. Kind of Busin	ess/industry
7	withi ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	nema ker			Own Ho	ımρ
2	filed Hygid Sther ent,		17. Father's Name (First, Middle, Last)		1101		. Mother's Name	(First, Middle, N	faiden Sumame)	, inc
an	Mental Mental arked o	o Be	Edgar Whitem	nan			Jessie	Fie	elds	
2	2 should and Men Is marke aumatic	70	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street and		l Route Number.	City or Town. Sta	te. Zio Code)
Maryland	d 2 sith ar		Marian E. Corrick	•		7 Queen Eli				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Items 23a or 28a-f show important: if Item 27 is marked other than "naturel; or Items 23a or 28a-f show any injury or other traumatic event, the Marical Examination mail to retiffied at ancient.		20a. Method of Disposition	,	20b. Place of Dispo	sition (Name of			20c. Location - Cit	
Baltimore,	Pages nent of U	1	1 ☐ Burial 2 🗷 Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		i + a n Coom	5/11	/0/	Alexandr	ria Va
臣	artme ortan injur		21. Signature of Funeral Service License	ne		itan Crem.				ia, va.
Ba	permit. Departitmports any inj		muriel d	Bark	Per /	Muriel H.	Barber	Funeral	Home	20002
			23a. Part1. Enter the disease, or complic	cations that caused	the death. Do not ent				ville, Mo	Approximate
			shock, or heart failure. List only on tmmediate Cause (Final	ne cause on each line	).	,	/ >			Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	cong	rsur	ehear	the	elle	e	10 days
<i>A</i> .	Examiner			Due to (or as a	consequence of):					
	5%	e.	Sequentially list conditions bif any, leading to immediate	Due to (or as a	consequence of):					
	uted Insit	Examiner	Cause (Disease or injury							
	be executed icien and burial-transit	Xa	that initiated events c resulting in death) Last	Due to (or as a	consequence of):					
760,	te be executed ysicien and se burial-transit	call								
89	it the death certificate by the attending phys tached for use as the	edic								
Box	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		-			23d. Date of	delivery
	death a atte	icia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year
o.	the cy the acher	hys	9 Unknown	9□ Unknown					17	
S, P	The law requires that the death certificate ite has been signed by the atlending phys page 2 should be detached for use as the	Completed by Physician/Medi	Part II. Other significant conditions con	tributing to death bu	not resulting in the u	nderlying cause given in	n Part I.	23e. Did tob	acco use contribu	te to the cause of death?
ğ	n sig	b b	Vitamus.	\$12de	ficie	ncy		1 □ Ye	s 2 🖪 No 3 🛭	Probably 4 Unknown
Vital Record	w requir s been si should	jete	Itavia.	Dank	entra			24a. Was ar	24b. Wer	e autopsy findings available
Re	he la e has age 2	E C						autopsy	led? prior	to completion of cause of h?
a	in: T ificat or, pi	Ö	25. Was case referred to medical			26	S. Place of Death	1 Yes 2		Yes 2□ No
5	s cert	To B	examiner?	lospital:	t 2 ER/Outpatien	Othor	1		nce 6 Other (	Specify)
of	Phy ar this aral c		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at			w injury occurred	Spacity)
Division	oding th.: Afte	to	1   Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year) Injury	Work? M 1 ☐ Yes	2 🗆 No			
/IS	Attendi r death. sctor: A sy the fu	if Co	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At home, farm, str	eet, factory, office	2	8f. Location (Str	eet and Number o	r Rural Route Number,
á	al or A after f Direction by	Certification:	4 Homicide	building, etc.	(Бреспу)			City or Town,	State)	
	spita nours nera fille		29a. Certifier 1 Certifying Phys	sicien: To the best of	my knowledge, death	occurred at the time, o	date and place, a	nd due to the ca	use(s) and manne	r as stated.
	To the Hospital or Attending Physician: The law within Z4 burns after death.  Yo the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examinone)	ner: On the basis of and manner stat	examination and/or invest.	vestigation, in my opinio	on, death occurre	d at the time, da	te and place, and	due to the cause(s)
	Totl withii Totl comp	Ň	29b. Signature and title of certifier			29c. License nu		29	d. Date signed (M	Ionth, Day, Year)
	V		Helpert &	miles	he lan	104	4115	1	nay!	0,2004
	V		30. Name and address of person who con	mpleted cause of de	ath (Item 28a) (Type,	Print)				
200			H. Robert Birsc			ussell Avei	nue, Gai	thersbur	rg, M̃d.	20877
ês.	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		Scarles				

			1 - For State Registrar		State of	Marylan		artmen rtificate					Reg. No.	200	-	16	799
п	Physici	an	Decedent's Name (First, Min	idle, Last)								2. Date of I Month	Day			3. Time o	
	/Medic			JO		BARR						MAY	9,	2004		9:02	2 P M
X	Examin	er	4a. Facility Name (If not institu	-				4b. City,		Location	of Death			County of D			
			LAUREL RI 5. Social Security Number	6. Sex		. Age (In yrs. I	ast hirthday	If Under		UREL If Under	24 Hrs.	8 Date of I		RINCE			or Foreign
	Funeral Director		577-28-0896 Usual Residence of Decedent		M 2 <b>X</b> F	81	Yrs.	Months	Days	Hours	Min.	8. Date of to (Month). FEB.	Day, Year) 27, 1	923 W	Country	Ce (State	C.
	/land		10a. State 10b. Cou	nty		10c. City	, Town or L	ocation			· · · ·				100	d. Inside C	ity Limits
	Man a-f-eh	to	MD PRIM	ICE G	EORGES			COLL	EGE	PARK						1 XYes	2 No
	or 284	by Funeral Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What	Countr	y?	
	23a	a C	9106 AU	OVIL	LE DR.				20	740				U.S.A	١.		
	tems	nue	11. Marital Status	- 1	12. Was Deced Armed Ford	es?	S. 13.	Was Deced If Yes, spec	ent of H ify Cuba	ispanic Ori in, Mexicar	igin? (Spe n, Puerto l	cify Yes or I Rican, etc.)	No-	<ol> <li>Race - A Black, W</li> </ol>			
36	s afte	Ϋ́	1 ☐ Never Married 2 ☐ M 3 ▼ Widowed 4 ☐ Divord		1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes 2	X No	Specify:				Specify:	THIT	1017	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f ehow fam Madical Eraminat must be notified at	ed b		lent's Educ		95.	16a. Dece	ident's Usua	l Occup	ation			16b. Kii	nd of Busine	WHI ss/Indu		
7.	n na	Completed	(Specify only hig	hest grade		40. F.)	(Give	kind of wor DO NOT us	k done d	during mos	t of worki	ng	100.10		3311130	3(1)	DIIC
212	d with	E O	Elementary/Secondary (0-12 12	,	College (1-4	+01 3+)		HANDI	CAP	AIDE			P.G.	CO.PU	BLI	C SCI	BUS HOOL
פַ	e file al Hyg othe vent,	BeC	17. Father's Name (First, Midd							18. Mothe	er's Name	(First, Midd	lle, Maiden	Sumame)			
Vlai	Menta Menta Mrked	To E	UNK.			WIL	LIAMS				UNK	<b>.</b>					
Maryland	2 sho and Is ma		19a. Informant's Name/Relation	nship (Typ	pe, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Num	ber, City or	Town, State	e, Zip C	Code)	
<u>~</u>	l and lealth m 27 her t		RICHARD E. BA	RR J	R./SON	20h B	9106 ace of Dispo			LE DI		OLLEG		K, MD.			
Baltimore,	T See 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic		emoval from Si	ate	emetery, cre	matory or ot	her plac	´ I				cation - City			
ţ	t. Partmen	. 9	` 4 □ Donation 5 □ Other  21. Signature of Funeral Servi			CI	HAMBER					2004	_	VERDAL			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-1 ehow early njury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Pulled ay Sin V	han	rbeug	M000	91 5	НАМВЕ 801 С	RS F LEVE	UNER/ LAND	AVE.	ME & RIV	CREMA' ERDAL	CORIUME, MD.	P. 20	A. 737	
	Physician /Medical Examiner		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or complicient only on	ACUTE	MYOCAI r as a consequ	RDIAL				cardiac o	r respiratory	arrest,		Ir	Approximation of the control of the	tween Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (c	ras a consequ	ienca of).								П		-
,092	ite be executed sysician and ne burial-transit	cal Examiner	that initiated events resulting in death) Last	c	Due to (o	ras a consequ	ience of):										
89		-		1115													
.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	23		th 2 ☐ Fetal nt at time of de	death 3	⊒Ectopic pre ⊒ Other (spe					.   2	3d. Date of o			Year
۵.	that the by detail		Part II. Other significant cond	litions con	tributing to dea	th but not resu	ilting in the u	inderlying ca	use give	en in Part I		23e. Dio	tobacco u	se contribute	to the	cause of o	death?
sp.	uires t	d by	CHRONIC OF	STRU	CTIVE L	UNG DIS	SEASE					10	Yes 2	□No 3□	Probab	oly 4 🗀	Jnknown
Records,	w require been si should I	Completed										24a. Wt	ıs an	24b. Were	autops	v findings	available
Re	The lav	duc										per	opsy formed?	prior t death	to comp	detion of c	
Vital		BeC	25. Was case referred to med	cal						26 Place	of Death	(Check only	2X No	101	es 2	□ No	
	di S	To B	examiner? 1 ☐ Yes 2 ☐ <b>X</b> No	н	ospital: 1 🗆 Inj	patient 2 🔀 I	ER/Outpatie	nt 3 DO	A Othe	25				Other (S	pecify)		
n of			27. Manner of Death 1 XNatural 5 ☐ Pen	dina	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury	f 28	3c. Injury Work	at	2	8d. Describe	e how injury	occurred			
Si Oi	Attending It death. Octor: Alte by the fune	atle	2 ☐ Accident inve	stigation				М	1 🗆 '	Yes 2 🗆	No						
Division	i ji te	Certification:		ld not be emined	28e. Place o building	f Injury · At ho g, etc. <i>(Specit</i> y	me, farm, st	reet, factory,	, office		2		(Street and own, State)	d Number or	Rural F	Ro <i>ute Nu</i> m	ber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 X Certification (Check only one) 1 Medication 1 Medic	ying Phys al Examin	ician: To the b ter: On the bas and manne	is of examinat	wledge, deat ion and/or in	h occurred a vestigation,	at the tim	ne, date an pinion, dea	d place, a	and due to the	e cause(s) e, date and	and manner place, and d	as state	ed. ne cause(s	i)
	To the within To the comp	Me	29b. Signature and title of cert	fier	1	1.1			License	number			29d. Date	signed (Mo	onth, Da	y, Year)	
			> Wille	2	1	Wa	ine	U MW		MI	391	6	M/	Y 10,	200	04	
	10		30. Name and address of pers			of death (Item	23a) (Type,	Print)	<								Said
			WILLIAM A.					RINCE	GEO	RGE S	ST.,	LAUREI	L, MD.	2070	7		- 11
	Sta Registr		31. Date filed (Month, Day, Ye			gistrar's Signat	ure &	Spa	che	/							

			1 - For State Registrar	State	of Marylar	id / Depa <i>Cei</i>	artment of H	lealth a Death	and Me	ntal Hyg	iene (	004	168	00
			Decedent's Name (First, Middle)	e, Last)					2	. Date of Dea	th	.,	3. Time of	Death
	Physici: /Medic		A	lice Mari	e Bell					May 8,	2004	Year	6:15	$A^{M}$
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	r Location of	of Death		4c. Cou	inty of Death		
			Montgomery Hosp	oice Case	y House		Rockv				Mont	gomer	y	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	* * *	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day	Year)	Coui	place (State of	r Foreign
	Director		577-30-0024	1 M 2 M F	78	Yrs.			A.	ug. 27	, 1925		ington,	D.C.
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ecation					1	0d. Inside Cit	ty Limits
	f sho	ō	Maryland Montg	Omorii		Monta	omery Vil	1000					1 🔀 Yes	2 🗌 No
	the 28a-	Director	10e. Street and Number	omery		Hontg	10f. Zip Code	Liage		1	0g. Citizen	of What Cour	ntry?	
	3a or	0	18802 Walkers (	Choice Ro	ad #4		208	86			Unite	ed Stat	es	
	ms 2	Funerai	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.	Was Decedent of H	ispanic Ori	igin? (Specif	y Yes or No-	14. F	Race - Americ	an Indian,	
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "netural", or items 23a or 28a-f show eumatic event, the Medical Eval. In trust the rediffied at	by Fur	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	Armed Fied 1 Tes	2 ፟∰No ive		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	1, Puerto Hit	can, etc.)		Black, White, ec <i>ify:</i> Wh	etc. nite	
9	thou stura	ed	15. Deceden			16a. Dece	dent's Usual Occup	ation			16b. Kind o	f Business/In	dustry	
15	nin 72 n "n	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed	) (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during mos d)	t of working				,	
212	d with giene or the	mo:	12	College	(1-401 57)	Recep	tionist				Hosp	italit	Э	
힏	al Hyg	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (/	First, Middle,	Maiden Sum	name)		
<u>a</u>	should band Ments marked umatic e	To	William Howard	l Galbrai	th	<del></del>		Ann	a Scar	n1on				
Maryland 21215-0036			19a. Informant's Name/Relations				ng Address (Street							
	l and fealth im 27 her tr		Donald Bell/Sor	1	20h (		Ivywood I	Drive	, Free			land 2		
0	Pages 1 nent of H ant: if Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		State Gai	cemetery crer	natory or other place leaven	(e)	May 1	1,				1 4
altimore,	rtmen rtant		`4 □Donation 5 □ Other (S			Cemete	ry		2004	4 3	TIVEL	Shrrus	g, Mary	Land
Ba	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	Carrisoo	M001	L98 Rc	Name and Address Dert A. 1 O West Mor	Pumph ntgom	rey Fu ery Av	ineral e., Roc	Home/ kvill	Rockvi e, MD 20	11e, I 0850-280	inc.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat								Approximate Interval Bety	e ween
	Pnysician		Immediate Cause (Final disease or condition	Lun	g Cancei							16	Onset and D	)eath
	/Medical Examiner		resulting in death)		(or as a consec									
	LAdillile	_	Sequentially list conditions, if any, leading to immediate	D. —			al Scler	osis				-		
	ed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	uence or):								
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c	(or as a consec	uence of):								
8760,	cate be executed physicien and the burial-transit	dlcai E												
89	ificate g phy as the	edlo		J										
Box	h cert andin use	In/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnation		Ectopic pregnancy					Date of delive	,	
O. B.	The law requires that the death certific ate has been signed by the ettending p page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🖾 No		nant at time of o		Other (specify)					Month	Day Y	'ear
<u>Р</u>	at the	Phy	9 Unknown											
	res that signed to be det	þ	Part II. Dther significant condition Hypertension,			uiting in the ui	nderlying cause givi	en in Part I.	•				ne cause of de ably 4 □U	
010	w require been si should t	eted	myper tension,	пуроспу	LOTAISM							, 3 <u></u>	ably 4 0	TIKI:O44:1
Sec.	: The law cate has b page 2 s	Completed								24a. Was a autops perforr	V	prior to cor	psy findings a npletion of ca	ivailable luse of
<u>=</u>											2 <b>%</b> No	death?	2 No	
Division of Vital Records,	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			t all post Other	or		Check only on				
o	Phys rthis ral di	- T	1 ☐ Yes 2 🛣 No  27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of	1 3 DOA	4 🗆 190		5 Reside			Hospic	:e
on	Attending Physicien: r death. actor: After this certific by the funeral director.	tlon	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mo	nth, Day Year)	Injury	Worl	k? Yes 2 🗍			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
/IS	l or Attendater death Diractor: A	ifica	3 Suicide 6 Could determ	not be 28e. Plac	e of Injury - At h	ome, farm, str	eet, factory, office		28f	. Location (St	reet and Nu	mber or Rura	I Route Numb	ber,
á	s afte al Dira ed in 1	Certification:	4   Homicide	Dulk	ding, etc. (Specia	y)				City or Towr	, 5(2(8)			
	To the Hospitel or At within 24 hours after d To the Funeral Diract completely filled in by	Medical	29a. Certifier 1 🔀 Certifyin (Check only one)	g Physician: To the Examiner: On the and ma	e best of my kno basis of examina nner stated.	owledge, death tion and/or in	n occurred at the time vestigation, in my of	ne, date an pinion, dea	d place, and th occurred	d due to the ca at the time, d	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)	
	ro the	Me	29b. Signature and title of certifie				29c. License	e number		2	9d. Date sig	ned (Month,	Day, Year)	
}			> I Carak	zunne			D605	582			May 8	, 2004		
	10		30. Name and address of person		ise of death (iter	п 23а) (Туре,	Print)							
_			Joyson Karakunn				er Mill F	Road,	Rockv	ille,	Maryl:	and 20	855	
	Sta		31. Date filed (Month, Day, Year)  MAY 1 0 2		Registrar's Signa	ature 4	Sports	,						
	Registr	ar	MAY 102	.004	The same of the sa		apours!							

			1 - For State Registrer	State of M	aryland .		artment of rtificate c			lental Hygi	ene g. No. 200	+ 16801
	Physici /Medi	cal	1. Decedent's Name (First, Middle, I	BIALE			T			2. Date of Death Month May 12,	Day Year 2004	4:55 A. <sup>M</sup>
	Examir Funeral	ner		ns Nursing		birthday)	4b. City, Town  Kensi  If Under 1 Ye  Months Day	ngton ar If Unde		8. Date of Birth (Month, Day, Feb. 12	4c. County of De MOntgome	ery inthplace (State or Foreign
	Director		130-01-7661  Usual Residence of Decedent  10a. State 10b. County	10 W 241	10c. City, T					Feb. 12,	, 1921 Net	York  10d. Inside City Limits
	th the Maryl or 28a-faho e notified a	Director	MD Montgome	ery	Silve			э		10	ng. Citizen of What C	1 ☐ Yes 2 No
036	be filed within 72 hours after death with the Maryland that Hygiene.  Identitien "natural", or flems 23a or 28a-f ahow od other than "natural", or flems 23a or 28a-f ahow avant, the Madical Examiner must be notified at	d by Funeral Director	1002 Whitehall S	12. Was Decedent Armed Forces	?					ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - Arr Black, Wh  Specify: V	ite, etc.
Maryland 21215-0036	e filed within 72 h al Hygiene. I other than "natu vant, Itte Mydica	Completed	15. Decedent's (Specify only highest of Specify only highest only highest of Specify only highest only highe	rade completed) College (1-4or		(Give life.	dent's Usual Occ kind of work doi DO NOT use ret Agent	ne during mo: ired)		ing	6b. Kind of Busines  Music (	,
ryland	0 = 0 %	To Be	17. Father's Name (First, Middle, La  Isadore	Ber	kowitz			Aı	nna		owitz	
e, Mar	ss 1 and 2 sh of Health and Item 27 la n other traun		19a. Informant's Name/Relationship Hyman Bialek / 20a. Method of Disposition	spouse		1002	Whiteha	all St	., Si	lver Spr	City or Town, State, ing, MD 2 0c. Location - City o	20901
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injury or other traumatic a once.		1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other Special 21. Signature of Fund al Sufvice Lic	cify)		Davie 22	. Name and Add	Garden dress of Facil	May ity Tor	14,2004 chinsky	Falls Ch Hebrew Fu	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Non-H	ine.	's L	er the mode of d	ying, such as	cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death 2 years
8760,	death certificate be executed e attending physician and of for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	c	a consequence							
P.O. Box 68	eath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnar Other (specify)	ncy			23d. Date of de Month	blivery Day Year
	w requires that the d been signed by the should be detached	leted by P	Part II. Other significant conditions	contributing to death b	out not resulting	g in the u	nderlying cause	given in Part I	l.			o the cause of death?
Vital Records,	The lar ate has page 2	Сошр									prior to death? No 1 \(\sum Yes	utopsy findings available completion of cause of
o	ding Phya .r After this funeral dii	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigati	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b	Outpatien o. Time of Injury	28c. In	other: 4XNI	ursing Hor	ne 5 Residen Red. Describe how	ce 6 ⊡Other (Spe	ecify)
=	tal or Attands after death	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of Inj	ury - At home, c. (Specily)	farm, str	eet, factory, offic	Ð	2	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or At within 24 hours after o To the Funerel Direct completely filled in by	edical	one)	Physician: To the best nminer: On the basis of and manner sta	r examination	ige, death and/or inv	occurred at the restigation, in my	time, date ar opinion, dea	d place, a	and due to the cau ed at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
f	To the complet	W	29b. Signature and title of certifier	Chor	wa	j	D00	058965	5		May 12, 2	
			30. Name and address of person who Saima U. Khawa	completed cause of d	leath (Item 288	a) (Type, ckvi]	Print) 1e Pike	#100,	Roc	kville,	MD 20852	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 13 2		ar's Signature	5	Spark	2				

			1 - For State Registrer	State	of Maryland		artment			and M		giene	2001	10000
	<b>S</b> 1		1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea	ith	-00-	3. Time of Death
	Physic /Medi		Eleanor H. Biggs								Month May	Day 9	2004	7:55 a M
	Examir		4a. Facility Name (If not institution, gi				4b. City, 1	Town, or	Location o	f Death		4c. C	ounty of Deat	th
			11919 Parklawn					kvi]					ntgome	ry
	Funeral Director		,	Sex 1 □ M 2 2 <b>X</b> F	7. Age (In yrs. Ia		Months	Days	If Under a	Min.	8. Date of Birth (Month, Day Jun 20	Year) 191	9. Birt	thplace (State or Foreign ountry)
	Pu .		Usual Residence of Decedent  10a. State 10b. County		10- 01-	Ŧ								
	sho	5				, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	the N	Director	MD Montgome	ry	Roc	kvill	10f. Zip (	0-4-					n of What Co	
	aa or		11919 Parklawn I	rive				0852				•	SA	ountry ?
	death ms 2:	Funeral	11. Marital Status	12. Was De	ecedent Ever in U.S		Vas Decede	ent of Hi	spanic Orio	jin? (Spe	cify Yes or No-		Race - Ame	ncan Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. sd other than "naturel", or flems 23a or 28a-f show event, I' a Medical Examiner must be indifficular.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tyes	Forces? s 2 X No Give	,	fYes, speci I□Yes 2	fy Cubar	n, Mexican	, Puerto I	Rican, etc.)		Black, White	
9	2 hou		15. Decedent's B	ducation	T	16a. Deced	lent's Usual	Occupa	tion			16h Kind	of Business/	Industry
215	hin 7.	Completed	(Specify only highest gi		(1-4or 5+)	(Give	kind of work OO NOT use	done d	urina most	of workii	ng	100.11.10	0, 540,11003	modelly
2	e filed within at Hygiene. I other than "	Con	12			Claim	s Adjı	ıste	r			Gove	ernmen	t
nd	m - 0 2	Be	17. Father's Name (First, Middle, Las					i			(First, Middle,	Maiden Su	mame)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be in Department of Health and Mental Importent: If item 27 le marked o any injury octoher traumatic evences.	P P	Fredrick H. Saye								Chapman			71
Mai	d2sthandthand7Tenttraun	-	19a. Informant's Name/Relationship		111						l Route Number			Zip Code)
e,	1 an Heall tem 2	1 3	Leonard A. Bauro	tn - s		480 / lace of Dispos			Road,		kville,		20852 ion - City or '	Town State
no I	ages onto		1 ☐ Burial 2 ☑ Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Special		n State cei	metery, cren	natory or oth	ner place						
Ħ	nit. F vartme orten injur injur		21. Signature of Funeral Service Lice		Meci	opolit	. Name and	The state of the later of the l		,	1, 2004			
ä	Per Per Per Per Per Per Per Per Per Per		1 La Stell			1			_	Frai	ncis J. C	Collin	ns Fune	ral Home, Inc
ļ,			23a. Part I. Enter the disease, or con shook, or heart failure. List only	plications that	t caused the death.	Do not ente	r the mode	of dying	, such as o	ardiac o	r respiratory arm	est,	opi ing	Approximate Interval Between
	Physician	a q	Immediate Cause (Final disease or condition		hemic Hea	rt Die	sease							Onset and Death 10 years
	/Medical Examiner		resulting in death)	· · · · · · · · · · · · · · · · · · ·	o (or as a conseque		Jease							10 years
j.	LAGITITIE	L	Sequentially list conditions,	b										
	ted sit	nine	Sequentially list conditions, I are leading to immediate cause. Enter Underlying Cause (Disease or injury	Cualo	o (or as a conseque	enea oty:								
	and and al-trar	Examiner	that initiated events resulting in death) Last	c	o (or as a conseque	ence of):	····							
8760,	The law requires that the death certificate be executed at the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d										
9	tificat ng phy as th	0												
Box	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnand		Ectopic preg	nancy				23d	Date of deliv	very
o.	e dea the at hed fo	sici	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		gnant at time of dea		Other (spec						Month	Day Year
₾.	that the de ed by the a detached t	Phy	Part II. Other significant conditions	ontributing to	doath but not rocult	ting in the	ala al deservi				OO - Didas			
Records,	w requires that been signed should be det	d by		orthodaling to	dodin but not result	ung in the un	derlying cat	12e Giver	in Fait I.					the cause of death?
Sor	w requ	lete												
Re	The lav	Completed		-	<del></del>						24a. Was ar autops perform	у _	4b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vital		e C	25. Was case referred to medical								1 ☐ Yes 2	. No	1 ☐ Yes	2□ No
	ysician: is certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 E	R/Outpatient	3[] DOA				(Check only one		Othor (Spec	2.3
Division of	g Phys ter this neral di		27. Manner of Death	1		28b. Time of		. Injury : Work?	at at		Bd. Describe ho			(1y)
jo	utending I death. ctor: After y the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	1	nin, Day 1 ear)	Injury	М		es 2 🗆 N	0				
Š	after death after death Director:	Certification:	3 Suicide 6 Could not be determined	288. Plac	e of Injury - At hom ding, etc. (Specify)	ie, farm, stre	et, factory,	office		2	Bf. Location (Str. City or Town,	reet and N	umber or Rur	al Route Number,
	urs af													
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 ☑ Certifying Pt (Check only one) 2 ☐ Medical Exar	niner: Op/the i	e best of my knowle basis of examination nner stated.	edge, death on and/or inv	occurred at stigation, in	the time my opi	, date and nion, death	place, ar occurre	nd due to the ca d at the time, da	use(s) and ite and pla	l manner as s ce, and due t	stated. to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certifier	/		1	29c. l	License	number		29	d. Date si	gned (Month,	Day, Year)
	6		1/1	~		1		2067	4			May 1	0, 200	14
	1		30. Name and address of person who								-			
	<sup>^</sup> Sta		Stephen M. Hellm 31. Date filed (Month, Day, Year)		0., 6240 I Registrar's Signatur					/ <b>i</b> 111	e, MD 20	0852		
	Registra	2.4	MAY 11 20	04	e signatur	19	Spa	Ks	_					

	,		1 - For Stata Registrar	State o	f Marylaı		artment of		and Mental Hy	rgiene Reg. No 2 ()	n I.	16903
	Physic: /Medi		Decedent's Name (First, Middle, La Ann BLA)						2. Date of De May 10	aath	Year	3. Time of Death 3:25 P M
	Examir		4a. Fecility Name (If not institution, given Anne Arundel Medi		,		4b. City, Town	olis	of Death	4c. County Anne A		e1
	Funeral Director	^		Sex 1□M 2□F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Ye Months Day		Min. (Month, Da	th	9. Birthpl Coun	lace (State or Foreign
	Maryland I-f show	tor	10a. State 10b. County Maryland Anne Ar	undel		ity, Town or Lo	cation				10	0d. Inside City Limits 1 ∑Yes 2 ☐ No
	th with the 23a or 28a	al Director	10a. Street and Number 619 Admiral Driv	e #202			10f. Zip Cod 21301	9		10g. Citizen of W		,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Modical Examinar must be natified at once.	Completed by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	rces? 2 No e	ŀ	Vas Decedent of f Yes, specify C	uban, Mexican	gin? (Specify Yes or No., Puerto Rican, etc.)	Blaci	e - America k, White, e <b>Whit</b> e	etc.
21215-0036	d within 72 ho piene. r than "natur the Medical	ompleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		-4or 5+)	(Give	lent's Usual Occ kind of work doi DO NOT use ret omemake:	ne during most ired)	of working	16b. Kind of Bu		lustry
Maryland 2	uld be filed Mental Hyg srked other	To Be C	17. Father's Name (First, Middle, Last Samuel Feldman	)					r's Name (First, Middle,		в)	
, Mar	and 2 sho lealth and m 27 Is m		19a. Informant's Name/Relationship (Madeline Cole, Dat		1	619 A	dmiral	Drive	r or Rural Route Number #202, Annar	er, City or Town, S	State, Zip	Code)
Baltimore,	t. Pages 1 rtment of H rtant: If ite		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special	(y)	State Ah	avath I	sition (Name of patory or other c STAEL (	emeter:		Liberty	y, N	
Ba	Dermi Depa Impo any is		21. Signature of runeral Service Lice		Support the deat	$\frac{1}{2}$	rchinsk Carro	Tress of Facility	w Funeral NW, Washi	Home ngton, I		0012
	Physician /Medical		23a. Part Effect the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A.	Spire or a conseq	hos	pneum		ardiac or respiratory at	rrest,		Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate	b. d	ement or as a conseq	-ca						>lyeur
8760,	icate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (d	or as a conseq	uence of):						
O. Box 68	death certifi e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown		nth 2∏Feta antattime ofd	I death 3 🗆	Ectopic pregnar Other (specify)	ncy		23d. Date Mont	of delivery	y Day Year
ecords, P.	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the un	derlying cause (	given in Part I.		obacco use contrib	bute to the	
r	The law ate has b page 2 sl	Completed							24a. Was autop perfor	sy pri med? de	ere autops for to comp eath?	sy findings available pletion of cause of
or Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No			R/Outpatient	3□ DOA C	Ale a m	of Death <i>(Check only or</i> sing Home 5 Resid		(Specify)	
	ding h. After fune	Certification;	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not b.	1	i, Day Year)	2 b. Time of Injury	M 1 {	ork? □Yes 2□N	0	ow injury occurred		
_	- 9		4 Homicide determined	buildin	g, etc. (Specif	y)	et, factory, office		City or Tow			
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medical	(Check only one)  2 Medical Example of Certifier	niner: On the bas	sis oi examina	tion and/or inve	estigation, in my	opinion, death	place, and due to the o occurred at the time, o	ate and place, an	nd due to th	he cause(s)
	F3F8		> Inf Tkl	un	MP		D =	24804		5/i1/god	Month, DE	ıy, Year)
	Ψ		30. Name and address of person who	terson		23a) (Type, P	rint)	чиоры	ls Mel a	21401		
	Sta Registra		31. Date filed (Month, Day, Year)  MAY 1 2 200	32. Re	gistrar's Signa	ture	Spark					

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>		nt of H		nd M		iene ag. No. 200		6806
	Physic /Medi	cal	Decedent's Name (First, Middle, Last)     PAUL DANIEL BOGART							2. Date of Deat Month MAY 12,	Day Yea 2004	3:4	ne of Death
	Examir	ner	4a. Facility Name (If not institution, give state of the CASEY HOUSE  5. Social Security Number 6. Sex	,	(In yrs. last birthday)	ROCK	v, Town, or VILLE er 1 Year	Location of		8 Date of Birth	4c. County of De	RY	ate or Foreign
	Funeral Director		061-44-3025 Usual Residence of Decedent	]M 2□F	38 Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day, NOV 8 9	1965 NEW	YORK	ate or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injuryer other treumatic event, the Mudical Exertification and once.	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educy Capecify only highest grade  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  DAVID  19a. Informant's Name/Relationship (Ty)  LAUREN BOGART/WIFE  20a. Method of Disposition  1 Marrial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Sign ture of Faural Service License	E  12. Was Decedent E Armed Forces?  1	BOGART  19b. Mailit 323 A  20b. Place of Dispocemetery, cres GARDEN OF	BURG  101. Z  Was Deo If Yes, sp  1  Yes  dent's Us kind of w DO NOT  PRES  LDER  sistion (Ni matory or  REM)  2. Name a WARD 91 R	as (Street a WOOD and Address SAGE OCKVI	18. Mother's  BETTY  nd Number  DR., (  P)  NCE OF  So of Facility  LE P	or Rura. GAIT DO 5/13 ERAL IKE,	(First, Middle, Market Number, CHERSBUR ate 2004 CONTROCKVI	MARKETING faiden Sumame)  City or Town, State, G, MD 208 Oc. Location - City or CLARKS BURG ION, INC. LLE, MD 20	nerican India nite, etc.  HITE sylindustry  ROTH Zip Code) 78 or Town, State	·e
	Physician /Medical Examiner pue u	Examiner	23a. Parid. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	GLIOBLAST  Due to (or as a	he death. Do not ent	er the mo	de of dying	, such as ca	ardiac or	respiratory arre	st,	Approxi	Between and Death
s, P.O	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con	Bc. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3 me of death 5	Other (s		n in Part I.			23d. Date of de Month	Day	
tal Recor		e Completed	25. Was case referred to medical					26 Diago of	f Dooth	24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findin completion	ngs available
Division of Vital Record	Attending Phys or death. ector: After this by the funeral dii	Certification; To Be	examiner?	28a. Date of Injury (Month, Day 1	/ - At home, farm, stre	М	28c. Injury Work 1 □ Y	4 ☐ Nursi	ing Hom	8d. Describe hov	ce 6 COther (Sperinjury occurred		
	Hospitel 4 hours Funeral ely filled	edical Ce	29a. Certifler (Check only one)  1   Certifying Physical Check Control one)	ician: To the best of er: On the basis of e and manner state	xamination and/or inv	occurred estigation	at the time	e, date and p nion, death	occurred	nd due to the cau d at the time, dat	se(s) and manner a e and place, and du	s stated. e to the caus	e(s)
<b>)</b>	To the To the complet	Me	29b. Signature and title of certifier	yme			c. License		_		1. Date signed (Mon.	•	r)
			30. Name and address of per on the of CHITRA RAVAGOPAL, 1	M.D., 1811	1 PRINCE		IP DR	IVE, #	‡327				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Hegistrar'		Spo	uks	,					

			1 - For State Registrar	State of Mary		artment of F		d Mental I		ne No.2004	16805
	Physic	an	1. Decedent's Name (First, Middle, La	st)				2. Date of Month		Day V-	3. Time of Death
	/Medi		William Cole					May	6,	Day Year 2004	7:50 PM
7	Exami	ner	4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of D	eath		4c. County of Dea	
			Montgomery Hosp: 5. Social Security Number 6.5	ce- Casey Ho	ouse	Rockvi				Montgo	mery
	Funeral Director			M 2□F	yrs. last birthday) Yrs.	Months Days		Min. (Month,			rthplace (State or Foreign ountry)
			Usual Residence of Decedent	82				Feb.	15,	1922   V	<u>irginia</u>
	irylan ihow	_	10a. State 10b. County	100	c. City, Town or Lo	ocation	-				10d. Inside City Limits
	Ba-fs	Director	Maryland Montgo	mery	Silver S	pring					1 ☐ Yes 2 ☑ No
	or 2	Dire	10e. Street and Number	-		10f. Zip Code			10g. (	Citizen of What Co	ountry?
	s 23s	rai	1119 North Belg			20902				USA	
10	ter dea	Funeral	11. Marital Status  1 ☐ Never Married 2 反 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin' n, Mexican, Pi	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
936	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:			Specify: Wh	ite
9-0	within 72 hours after death with the Maryland ane. then "naturel; or items 23a or 28a-f show is Marical Exercited to all find at	Completed	15. Decedent's E	ducation	16a. Deced	tent's Usual Occupa	ation		16b.	Kind of Business	/Industry
21	d within 72 ho piene. r then "natur r e Medical	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	furing most of )	working			,daday
21	70 10 10 10	Con	12		Pri	nter			S	Servicema	an
and	ed la be	Be	17. Father's Name (First, Middle, Last,				18. Mother's	Name (First, Mid	dle, Maide	en Sumame)	
3	d 2 should be th and Mental 7 Is marked o traumatic eve	P	Phillip Cole Bri					t. Clai			
Maryland 21215-0036	2 6 8 2		19a. Informant's Name/Relationship (  Isabella Brizer			g Address (Street a					
	of Health of Health item 27 I		20a. Method of Disposition		Db. Place of Dispo	NOTTN Be sition (Name of	elgrade	Road, S			g, MD 20902
<u>o</u>	ages ent of it: If ii		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cernetery, cren Gate of 1	natory or other place	Ma	ay 11, 2004	20¢.	Location - City or	rown, State
Baltimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot		21. Signature of Funeral Service Licer		Cemet	Name and Address	s of Facility	2004	Si	lver Spr	ing, Maryland
ñ	Dep Imp		Ruchard I Ha		Fr	Name and Addres	Collin	s Funera	1 Ho	me Inc.	
			23a. Part1. Enter the disease, or com	olications that caused the	death. Do not ente	or the mode of dying	, such as card	Vd. W., diac or respirator	S1IV arrest.	er Sprin	g, MD 20901 Approximate
	Physician		Immediate Cause (Final	one cause on each line.				, ,			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Advanced  Due to (or as a con		cer					Greater than
	Examiner		Sequentially list conditions,	b							
	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):						
	and -trans	Examiner	that initiated events resulting in death) Last	c							
8760,	cate be executed physician and the burial-transit	a E		Due to (or as a con	sequence of):						
687	phys phys s the	dicai		d							
	The law requires that the death certific lie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pre	egnancy			9/	- 1		
Вох	d for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of deliment	very Day Year
o.	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown		- (openiy)			-		
ري ص	es tha igned I be det	by P	Part II. Other significant conditions of	entributing to death but not	resulting in the un	derlying cause giver	n in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
ğ	w require been sig should b	edi	Recurrent Hyperca	lcemia				_ 1[	Yes 2	2⊠No 3□Pro	bably 4 Dunknown
Records,	law re as be 2 sho	Completed						24a. Wa	as an	24b. Were aut	opsy findings available
_		E O						_ per	topsy formed?	prior to o	ompletion of cause of
Vital	sicien: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of D	eath (Check only		o 1 ☐ Yes	21110
0	this ald	၉	1 ☐ Yes 2 🙀 No		ER/Outpatient	3□ DOA Other	4 Nursing	Home 5□Re	sidence	6 ∰Other (Spec	ify) Hospice
Division of	ding P h. After t funera	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work?	at	28d. Describe	э how iлju	iry occurred	
Sic	death death ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	CO. Blace of let			9s 2 No				
2	l or Atten after deatl Director: i in by the	ertif	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	it home, farm, stre ecify)	et, factory, office		28f. Location City or T	(Street allown, State	nd Number or Rur e)	al Route Number,
	spite		29a. Certifier 1 <b>∑∕Certifying</b> Phy	sicien: To the best of my	cnowledge death	accurred at the time	data and -la	1			
	e Ho Fui letely	Medical	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	ination and/or inve	estigation, in my opin	nion, death oc	ce, and due to the curred at the time	e cause(s e, date an	<ul> <li>and manner as s</li> <li>d place, and due t</li> </ul>	stated. to the cause(s)
	To the Hospitel of within 24 hours at To the Funerel D (completely filled it	Me	29b. Signature and the of seather	10		29c. License	number		29d. Da	ite signed (Month,	Dey, Year)
	///		Walter Constitution of the	the		041	1218			17/211	1
	>		30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type, P		_~_0		2	17104	
			Charles Harrison			Mill Roa	d. Roc	kville.	MD 1	20855	
	Stat	-	31. Date filed (Month, Day, Year)  MAY 1 1 200	32 Registrar's Sig	nature 4	Sporks	.,		111/2		
	Registra			1 /75 444							

State of Maryland / Department of Health and Mental Hygiene 16806 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2004 **Physician** Month Year 11:00 a M Elizabeth Madden Brown May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4011 Blackpool Road Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖫 F Director Yrs. 303-26-0061 80 Feb. 7, 1924 Indiana Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Mudical Exer insermust be notified at Director 1 ☐ Yes 2 ☑ No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 4011 Blackpool Road or Itams 23a 20853 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should ba filed within 72 hours after a and Mental Hygiene. 1 Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If item 27 is marked other th
any Injury or other traumatic avant, this 4 Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore B. Madden 2 Theresa C. Kessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Robert Brown/ Husband 4011 Blackpool Road, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation = 5 □ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Colon Cancer disease or condition resulting in death) 2 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown yd ber Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign. Advanced Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3₺ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 70 1 ☐ Yes 2 🛣 No Đ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification; 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation hin 24 hours after death. the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36252 (1 May 7, 2004 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp Steven T. Kariya M.D. 11501 Georgia Avenue, #515, Wheaton, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 0 2004 MAY sacker Registrar

		State Registrar  Decedent's Name (First, Middle, Las  The state of th	e)	Ce	ertificate	of Death		3 1111 00	004 168
Physicia	n						2. Date of De Month	Day	Yeer 3. Time of De
/Medica	al -	Louis Claude Burc  4a. Facility Name (If not institution, give			4h Cihi T	and and antique of D	5-9-0		4:59 A
Examine	er	Washington Advent		1		own, or Location of De a Park	atn		ty of Death
Funeral		5. Social Security Number 6. Se		yrs. last birthda			rs. 8 Date of Bi		t gomery
irector		578-03-0716 Usuel Residence of Decedent	M 2□F 80		Months	Days Hours Mi	75. 8. Date of Bi (Month, Di 6-21-]		9 Birthplace (State or F Country) Wash., D. C
Mow E		10a. State 10b. County	10	c. City, Town or I	Location				10d. Inside City I
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or 28	Ole Ole	10e. Street and Number			10f. Zip C	Code		10g. Citizen o	f What Country?
23a	<u>a</u>	7221 Garland Ave	•		20	912		U.S.A.	
ide nyberie. id other than "natural", or itams 23a or 28e-f ehow event, itte Medical Evarnicer med be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 GYes 2 □ No If Yes, Give Year or Dates:	WWII	3. Was Decede If Yes, specif 1 Yes 2	nt of Hispanic Origin? y Cuban, Mexican, Pue X No Specify:	(Specify Yes or No arto Rican, etc.)		ace - American Indian, lack, White, etc. hity: White
Medical E	pleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	16a. Dec (Giv life.	edent's Usual ve kind of work DO NOT use	Occupation done during most of w retired)	orking	16b. Kind of	Business/Industry
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oth v	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle		
s marked o	<b>10</b>	Albert A. Burch				Florin	e Hyde		
le me		19a. Informant's Name/Relationship (T	ype, Print)	19b. Mai	iling Address (	Street and Number or I	Rural Route Numb	er, City or Town	n, State, Zip Code)
tem 27		Raymond Burch -	Son	7221	Garla	nd Ave. Tal	koma Parl	s. MD 2	0912
£ 5 5		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐		Ob. Place of Disp cemetery, cri	position (Name ematory or oth	of	Date		- City or Town, State
( F = 1		*4 □Donation 5 □Other (Specify		Gate of	Heaven	5-1	3-04	Silver	Spring, MD
Department of nearer and wer Important: if Item 27 is marke eny injury or other traumatic since.		21. Signature of Funeral Service Licens	see /	2	22. Name and	Address of Facility	Hines-Ri	naldi F	
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To the Hospital or Attending Physician:
within 24 hours after death.
To the Funeral Director: After this certifical completely filled in by the funeral director;

State Registrar

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

Examiner

Physician/Medical

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Completed

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Certification:

**Funeral** 

Director

Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Extrainment must be multiped at

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If tlem 27 is marked other than "ne any injury or other traumetic event, the Mode once.

**Physician** 

Examiner

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

use as the burial-trar

iding physician

filed withIn 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) MAY 10 2004

32. Registrar's Signature

9 Sparks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#26 1- State Registrar WCHD 05/07/04 ead Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Xi lisbu Wicsonico erson St If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 F 219-19-8348 Yrs. MI Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f ahov tre Medical Examinar must be notified at MD 1XYes 2 □ No Wicomico Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 21804 Funerai 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Peges 1 end 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: t Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ BIACK 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Heelth and Marial Hygiene. Important: If Item 27 is marked other ther any injury or other traumatic event, LAN ODCS. STuden7 10 th Grad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) STerling BOYd mantha 19a. Informant's Name/Relationship (Ty , Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury 20b. Place of Disposition (Name of cemetery, crematory or other place) 619 Simonthe Buyd c. Location - City or Town, State Date 20a. Method of Disposition

Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Menry Grade 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility permit. 21. Signature of Funeral Service Licensee to softone hnusmi 23a. Part1. Enter the disease, or complications to t caushock, or heart failure. List only one cause the Approximate Interval Between Onset and Death the death. the mode of dying, sich as cardiac or respiratory arrest, Immediate Cause (Final mm Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Discuss or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by to 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate has I rector, page 2 s 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: t ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Yes 2 No 2 Trvoupation 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death within 24 hours after death To the Funerel Director; / completelly filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2/2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. Licens (Month, Day, Year) 29b. Signature and title of certife 29d. Date Cooper completed cause of death (Item 23a) (Type, Print) 06 Milford

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Suite

100			1 - For State Registrar	State of Ma	arylan	d / Depa	artment of tificate of	Health Death	and M		giene Reg. No.	2004	1681
	Physici /Medic		Decedent's Name (First, Middle, Las     Ruth	t)		Barro	ws			2. Date of De Month May	Day	, 2004	3. Time of Death 9:00A
	Examin		4a. Facility Name (If not institution, give 12010 Marylan		Pos	d	4b. City, Town,		of Death		4c. Co	Cla o a 1	
2	Funeral		5. Social Security Number 6 Se	7. Ag		last birthday)	Nanj	If Under		8. Date of Birt	h	Charl	.es plece (State or Foreign ntry)
are de	Director		577-07-3561	_м <b>Ж</b> .г	99	Yrs.	Months Days	Hours	Min.	Sept.	6 19	904 Cour	MD
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Ba-f s	ctor	MD Charle	s	N	anjem							1 ☐ Yes 2 🗽 No
	death with the Maryland ms 23a or 28a-f show	Dire	10e. Street and Number 12010 Maryland	Point R	4		10f. Zip Code 206	560			10g. Citizer	n of What Cour	ntry?
	death ms 23	neral	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13. \	Was Decedent of f Yes, specify Cul		rigin? (Spe	cify Yes or No	- 14.	USA Race - Americ	
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5-0036	a within 72 hours after dea piene. r than "natural", or Items Ite Medical Ex., piner is	d pa	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:			lent's Usual Occu					of Business/Inc	
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	2 should be and Mental is marked raumatic ev	ī	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Stree	-					
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baitimore,	of He of He If item or oth		20a. Method of Disposition  20a Purial 2 Cremation 3		20b. P	lace of Dispo emetery, cren	sition (Name of natory or other pla	эсө)		ate		tion - City or To	
Ē	t. Pag rtment rtant:		* 4 □ Donation 5 □ Other (Specify	)	Wa		ational						MD
ä	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other QDCE.		21. Signature of Funeral Service Licen:	01/12	1009	45 Å	REHART	ECHO	ĽS F	UNERAI	HOM	IE, PA	
^			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused	the death	h. Do not ent	• U • BOX er the mode of dy	ing, such as	LaP s cardiac o	Tata, Nor respiratory ar	1D_20 rest,	1646	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			stive	e hea	rt 1	Cai	1410			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as					1				
¥	*:	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	ā Conseqi	uerice of).							
	ate be executed hysician and the burial-transit	Examiner	that initiated events	С.									
Ď,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):							
09/89	physic physic the b	edicai		d	<u>-</u>								
ŏ	uires that the death certifics signed by the attending pt d be detached for use as t	n/Me	230. Was decedent pregnant	23c. If yes, outcome			(F-4i				23d	I. Date of delive	ry
2	e death	Physician/M	in the past 12 months?	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pregnand Other (specify) _					Month	Day Year
<u>ب</u>	hat the		9 ☐ Unknown  Part II. Other significant conditions or		ut not resi	ulting in the ur	nderlying cause o	ven in Part I	f.	23e. Did to	bacco use	contribute to th	e cause of death?
cords,	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	d by					, and any and a great gr			T			ably 4 □Unknown
ဝ၁	aw require as been si 2 should b	ompleted								24a. Was		4b. Were autor	osy findings available inpletion of cause of
Ī	The ate ha	Com								perfor	med? 200 No	death?	2 No
VIII	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			10:			(Check only o			
0	Phy ratio	1; To	1 Yes 2 No 27. Mager of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da)		ER/Outpatien 28b. Time of	28c. Inju	iryat		ne 54 Resid		Other (Specify	7)
0	Attending Fir death. ector; After by the funera	ation;	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury		ork? ]Yes 2.∐	]No				
UIVISION	or Atterde	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.	ury - At ho c. <i>(Specif</i> )	ome, farm, stre	et, factory, office		2	28f. Location (S City or Tow		lumber or Rura	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifying Phy	ysician: To the best	of my kno	wledge, death	occurred at the t	ıme, date ar	nd place, a	and due to the o	ause(s) and	d manner as st	ated.
	the Ho nin 24 the Fu	ledical	one)	iner: On the basis of and manner sta	f examinat ated.	tion and/or inv			ath occurre				
	To Toon	Σ	29b. Signature and title of certifier				-	se number	70	59	29d. Date si	igned (Month, I	Day, Year)
			30. Name and address of person who d	ompleted cause of d	eath (Item	23a) (Tune		00	00	9 1	2	12/0	(
1	86		Jean A. Schoon	over,M.D	. 40	4 Eas	t Char	les S	St. I	La Pla	ta.MI	D 2064	6
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 4	32. Redistr	ar's Signa	ture	Coats &						· · · · · · · · · · · · · · · · · · ·
	negistr	11		- San San All		19							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- State of Maryland / Department of Health and No.		Reg. No. 200	+ 16811
Dhysia		Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time of Death
Physic Medi		Mary Jane Beckwith  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	5 -	13 -200 4 4c. County of Dea	1 2:50 P.M
Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  SACRED HEART HOSPITAL CUMBERLA/	VD	ALLE (	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir Mar 24,		thplace (State or Foreign
Director		220-16-6361 Yrs. Months Days Hours Min.	Mar 24,	1923	V V V
yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Ba-fs	Director	MD Allegany Cumberland	<del></del>		X Yes 2 No
with the		10e. Street and Number 10f. Zip Code 21502		10g. Citizen of What C	ountry?
death ms 23	Funeral	135 N. Mechanic Street  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No	)- 14. Race - Am	
36 after or ite		1 Never Married 2 Married 1 Yes 2 No	nican, etc.)	Black, Wh	
ING 21215-0036  be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "naturel", or Items 23e or 28e-f show event, the Medical Exerting must be nutified at	Be Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	
275 thin 72 en "na Medik	plet	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	=		•
I 21 lled wi tygien her th	Cou	12 Caregiver		Healthcare	
ITYIANG 21215-0036 should be filed within 72 hours after death with the Marylar nd Mental Hygiene, marked other then "naturel", or Items 23e or 28e-1 show matic event, the Medical Examinar must be nutifiled at	To Be	Henriett	a (John	son) Young	ər
Maryland 21215-0036 td 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other then "naturel", or treumstic event, the Medical Exer-	۲	Walter Younger  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rur  501 Jones Falls Court	al Route Numb	er, City or Town, State	₹3°2'0721
		Richard Beckwith son of the son o	Date	20c. Location - City o	
Baltimore, Dermit. Pages 1 ar Department of Hea Importent: If Item inny injury or othe		comptent crematon or other place)	5/16/2004	Cresaptow	140
Baltimol permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ho	ome, PA		
		108 Virginia Avenue	e: Cumbel	rland, MD 2150	
		23a. Part1. Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to or as a consequency of it.			Salays
Examiner		Consocked Heart to	Mure	•	
De si	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.   Due to (or as a consequence of):  (Indumary Tributy D	14 /	- 1	
al-tran	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of).	15/4	5/	
GELEER, tificate be executed tig physician and as the burial-transit	edical	d			
		IF FEMALE:			
Box 6 eath certific	cian/	23b. Was decedent pregnant   23b. Was decedent pregnancy   1 Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)		23d. Date of de Month	elivery Day Year
tthe d	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown			
Records, P.O. Box The law requires that the death cer the has been signed by the attendir page 2 should be detached for use	by	Part ii. Other significant conditions contributing to death but not resulting in the uncertying cause given in Part i.	23e. Did t	obacco use contribute t Yes 2 → No 3 ☐ F	rothe cause of death?
ecords, faw requires t as been signe	eted	HTTHEIMERS DEMENHA	24a. Was		
The lav	Completed		auto	psy prior to death?	utopsy findings available completion of cause of
	0	25. Was case reterred to medical 26. Place of Deat			s 2□No
of Vita Physician: rthis certifician	To B			dence 6 Other (Spe	əcify)
on c	tion:	27. Manner of Death  1.	28d. Describe	how injury occurred	
DIVISION I or Attending after death. I birector: Afte	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (	Street and Number or F	lural Route Number,
Distal or are after rel Distal in Hed in					
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 11 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Me			29d. Date signed (Mon	th, Day, Year)
$\wedge$		Money (Myll n D 35735		5/14/0	94
0		30 Hamp and address of person who completed cause of death (Item 23a) (Type, Print)  Shows E Nam M M D 9/2 Setzy D	Juni	holand	MID
St	ate	31. Date filed (Month, Day, Year) /32. Registrar's Signature	CH FIL VA	1 - 1 - 1 - 1 - 1 - 1	
Regist	rar	MAY 2 6 2004 General & Sparker			

		1 - State Registrar	State of Maryla		artment of H			giene 200	4 16812
Physici	an	Decedent's Name (First, Middle, Last)     SARAH F. CAI					2. Date of Dea Month		
/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Gaither			4c. County of De	
Funeral Director		5. Social Security Number 6. Sex 216–22–1209		. last birthday) Yrs.	If Under 1 Year Months Days			(Year)	ery intholace (State or Foreign Sountry) shington D.C.
Maryland a-f show	ctor	Usual Residence of Decedent		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
with the	Director	10e. Street and Number 9728 Huntmaster Ro			10f. Zip Code	200	1	Og. Citizen of What (	•
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examinar must be notitled at	by Funerai		12. Was Decedent Ever in the Armed Forces?  1 ☐ Yes 2 ▼ No If Yes, Give	1	208 Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No- irto Rican, etc.)	United St  14. Race - An Black, Wh  Specify: W	nerican Indian, ite, etc.
215-00 ithin 72 hour be an 'netural	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decec (Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	during most of w	orking	16b. Kind of Busines	s/Industry
Maryland 21215-0036 d 2 should be filed within 72 hours at the and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exemptraumatic event.	To Be Cor	17. Father's Name (First, Middle, Last) Aloysius Fealy	2	Exec	utive		ame (First, Middle, M	Trucking Maiden Sumame)	Industry
Aaryla 2 should 1 and Men 1s marks raumatic	-	19a. Informant's Name/Relationship (Type	,			and Number or F	Rural Route Number	; City or Town, State,	
Baltimore, Marylar permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any jujuy or other traumatic and once.		Kathy Bohrer (Daug  20a. Method of Disposition  1   ↑ Burial 2 □ Cremation 3 □ R  ↑ 4 □ Donation 5 □ Other (Specify)	20b. emoval from State	Place of Dispo cemetery, cren	sition (Name of natory or other place	e) May	Date 15.	ur Md. 20c. Location - City o	r Town, State
Baltir permit. P Departme Importan any injur		21. Signature of Funeral Service License		22	Heaven Cen Name and Addres O East De	s of Facility D	eVol Fune	Silver Spr ral Home hersburg,	
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Pancreatic (  Due to {or as a conservation of the conservation of	th. Do not ente					Approximate Interval Between Onset and Death 6 Months
cate be executed Experience of the purial-transit of the burial-transit ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of in jury that initiated events resulting in death) Last	Due to (or as a consec							
death certif	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	ac. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	- Pail		23d. Date of de Month	Divery Day Year
S, es th:	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause give	in in Part I.			o the cause of death?
The law ate has be page 2 s	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
ng Phys	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2  No H.  27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	3□ DOA Othe 28c. Injury Work	r: 4 ☐ Nursing I	ath (Check only one Home 5X) Resider 28d. Describe ho	nce 6 Other (Spe	ocify)
To the Hospital or Attending Results 24 hours after death or To the Funeral Director; After completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office		28f. Location (Str. City or Town,	reet and Number or R , State)	ural Route Number,
Mospi 24 hour Funer etely fill	edicai	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occi	e, and due to the caurred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
V Within To the comple	Me	29b. Signature and title of certifier	h		29c. License			Ay 12	
		30. Name and address of person who con		m 23a) (Type, F		-		10 20707	
· Sta Registra		31. Date filed (Month, Day, Year)  MAY 1 3 200	32. Registrar's Signa	sture &	Asas de	<u> </u>	ITV LEL P	V3 60 (0)	

			1- State of Maryland / Depa	rtment of Health and Mental H	ygiene Reg. No. 2004   6813
			Decedent's Name (First, Middle, Last)	2. Date of D Month	
	Physici /Medic		John Joseph Chirichella	May	10 2004 11:40 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Francis		Montgomery General Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Olney If Under 1 Year   If Under 24 Hrs. 8. Date of B	Montgomery
Н	Funeral Director		215-20-3989 <sup>1</sup> √2□F 77 Yrs.	Months Days Hours Min. (Month, E May 27	on the state of th
	D .		Usual Residence of Decedent		
	shov	ō	MD Montgomery 10c. City, Town or Loc		10d. Inside City Limits 1 ☐ Yes 3₺☐ No
	28a-f	Funeral Director	10e. Street and Number	Spring 10f. Zip Code	10g. Citizen of What Country?
	3s or	D	609 Windmill Lane	20905	USA
	deatl	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. W Armed Forces?	/as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
36	s after	by Fu	1 Never Married 2 Married 1 Tes 2 No	☐ Yes 2☑ No Specify:	Specify: White
Ö	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel", or items 23s or 28s-1 show event, the Modical Examination invalue incitied at	ed b	3 Widowed 4 Divorced Year or Dates:	ent's Usual Occupation	16b. Kind of Business/Industry
215	within 72 ene. than "na	Completed	(Specify only highest grade completed)  (Give k  Elementary/Secondary (0-12)  College (1-4or 5+)	ind of work done during most of working O NOT use retired)	Too. Isla of Business Midus (ry
21	od will	Som	10	rician	Union
p	be filed Ital Hygi of other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	e, Maiden Sumame)
Z Za	2 should be and Mental is marked sumatic ev	은	Pasquale Giovanni Chirichella  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	Maria Nich	
Maryland 21215-0036	id 2 sl lth and 27 is r traur	H		Address (Street and Number or Rural Route Num	
	f Healitem		20a. Method of Disposition 20b. Place of Dispos	atani'ar athar alasal	20c. Location - City or Town, State
Ë	Page int: if		4 Donation 5 Other (Specify) The Gate of He	eaven May 14	Silver Spring, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licensee 22.	Name and Press of Cility Francis J	. Collins Funeral Home
	2072 29		Clames & Care 500	O University Blvd. W. S:	ilver Spring, MD 20901
			23a. Part1. Anter the disease, or complications that saused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	within long disease	<
И	Examiner		Due to (gras a consequence of):	verine long disease.	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	acuted	Examine	that initiated events	<u> </u>	
8760,	icate be executed physicien and s the burial-transit		Due to (or as a consequence of):		
687	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical	d <u>29,3,,</u>		
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
	death e atte	icia	in the past 12 months?  1 yes 2 No.  4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Month Day Year
P.O.	that the de sed by the a detached f	hys	9 ☐ Unknown		
	res tha signed be det	by	Part II. Other significant conditions contributing to death but not resulting in the und		tobacco use contribute to the cause of death?  Yes 2 \( \subseteq \text{No} \) 3 \( \subseteq \text{Probably} \) 4 \( \subseteq \text{Unknown} \)
Sorc	law requires as been sign 2 should be	etec	(1)		
Rec	o - o	Completed	Hypernatte mia.	24a. Wa auto peri	s an 24b. Were autopsy findings available prior to completion of cause of death?
Vital Records,	iclan: Th certificate rector, pag	0	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only	2 No 1 Yes 2 No
f∨i	S S S	To B	examiner? 1 ☐ Yes 2 No Hospital: ↑ Inpatient 2 ☐ ER/Outpatient	Othor	
n of	ding Pt. After th funeral		27. Manner of Death 1 ☐Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		how injury occurred
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No	
Division	l or Attendatter deatter deatter deatter Director:	Certification;	4 Homicide determined 288. Place of Injury - At nome, farm, street building, etc. (Specify)	City or To	(Street and Number or Rural Route Number, own, State)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier XB Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
	n 24 h	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or inversely and manner stated.	stigation, in my opinion, death occurred at the time	, date and place, and due to the cause(s)
	vithi To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Dale signed (Month, Day, Year)
	12		11/1/	733071	14104. 10. 2001.
	1		30. Name and address processor who completed cause of death (Item 23a) (Type, P	many Blud, Beiserda	, MD, 20877.
	Sta Registr		31. Date filed (Month, Day, Year) MAY 13 2004  32. Registrar's Signature	29c. License number  29c. License number  27c. License number  28c. License number  29c. License number  29c. Accordance to the lime	

			. For	State of Marylar	nd / Depa	artment of H	Health and M	•		1 1 2
			1 - State Registrar		Cei	rtificate of	Death			
п	Physici	an	Decedent's Name (First, Middle, Las					2. Date of Deat Month	Day Yeer	3. Time of Death
)	/Medic	al	ALBERT  4a. Facility Name (If not institution, give	W. CLIPI	PER	4h City Town o	or Location of Death	MAY 5	4c. County of Dea	2:00 P M
	Examin	er	Brooke Grove (		h Ctr		dy Sprin		MONTGO	
	Funeral		5. Social Security Number 6. Se			If Under 1 Year	If Under 24 Hrs.			
9.	Director		220 14 4413	NM 2□F 92	Yrs.	Months Days	Hours Min.	Mar. Day	9. Bird 7, 1912	hplace (State or Foreign bunity) Maryland
	and		Usual Residence of Decedent  10a, State 10b, County	10c. Ci	ty. Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	Ď	MD Monto	gomery	5	andy Sy	orina			1 XYes 2 □ No
	r 28a	lrec	10e. Street and Number			10f. Zip Code	J	1	0g. Citizen of What Co	Lountry?
	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. do ther than "natural", or Items 23e or 28e-f show event, I're Medical Exama he must be mailfied at	Funeral Director	19004 Chandl	Lee Mill Roa	ad		20860		U.S.A	•
	tems	nuel	11. Marital Status	<ol> <li>Was Decedent Ever in U Armed Forces?</li> </ol>	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
30	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	Black
	2 hou	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business/	Industry
בן ב	within 72 ene. than "nai	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ing	Contee	
	filed wi Hygien other th	Co	9th		F	'oreman			Constr	uction
_	be fill htal H od oth	0	17. Father's Name (First, Middle, Last) Harry Clippe	a <b>r</b>			18. Mother's Name	,	- /	
Maryland	should be id Menta marked matic ev	우	19a. Informant's Name/Relationship (T		10h Mailie	a Address (Ctrast		y Washi	ngton  City or Town, State, 2	7-0-4-1
2	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumetic evonce.		Rosalin Clippe	<i>™G</i> rand− ≧r (daughter	~) 17		hler Ro			20832
ē,	Head item	1	20a. Method of Disposition	20b. F		sition (Name of natory or other place			20c. Location - City or	
Baltimore,	Page nent o int: if Iry or		1  Burial 2  Cremation 3  □ 1  Other (Specify)			Church		10/04	Germanto	wn, MD
<u>a</u>	armit. apartr aports ny inju	İ	21. Signal re of Funeral Service Liouns	100 X 10/11/6/			ss of Facility SN(	OWDEN F	UNERAL H	OME, P.A.
Ш	405 # g		Mary .	BIGUER					ville, M	
		1	23a. Part 1. Enter the disease, or compositors, or heart failure. List only of	ne cause on each line.	th. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Previous						4 days
21	Examiner			Due to (or as a conseq	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Chasses of Injury)	b. Due to (or as a conseq	quence of);					
	acuted ind transi	Examiner	Cause (Disease or injury) that initiated events resulting in death) Last	c						
/60,	te be executed ysicien and e burial-transit	cal Ex	resulting in death) Last	Due to (or as a conseq	quence of):					
-				d						
XOD	leath certificate attending phy I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of deli	verv
ň	the death y the atter iched for u	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d		Ectopic pregnancy Other (specify)	·		Month	Day Year
5	that the de led by the a detached f	hys	9 Unknown	9 Unknown				_		
Š,	law requires that as been signed b 2 should be deta	by	Part It. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.		acco use contribute to	
cords,	neen (	eted						-	_	obably 4 Onknown
Le Le	The law ate has page 2 s	ompleted						24a. Was an autopsy perform	prior to c	topsy findings available ompletion of cause of
	ictan: The lav certificate has rector, page 2	e Co	25. Was case referred to medical				26. Place of Death	1□ Yes 2	☐ No 1 ☐ Yes	2 □ No
	iding Physician: th. : After this certifical funeral director, I	0 8	examiner?	Hospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Oth			nce 6 Other (Spec	iifv)
0 0	ng Ph	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injun Worl	v at	28d. Describe how		.,,,
SIO	eath. or: Al	catle	2 Accident investigation			M 1 🗆 '	Yes 2 □ No			
DIVISION	or Attano after death Director: in by the	Certificat	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre y)	et, factory, office	:	28f. Location (Str. City or Town,	eet and Number or Ru. State)	ral Route Number,
_	spitel ours a narai [		29a. Certifier 1 TCertifying Phy	sician: To the best of my kno	wledge death	occurred at the tim	ne date and place	and due to the car	uso(s) and manour as	stated
	To the Hospitel or Attanding within 24 hours after death.  To the Funaral Director: After completely filled in by the fune.	edical	(Check only 2 Medical Exemione)	iner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my of	pinion, death occurre	ed at the time, da	te and place, and due	to the cause(s)
	vithir To th	Me	29b. Signature and title of certifier			29c. License	e number		d. Date signed (Month	
	5		1 Clautoph	Drougs mil	۵.	SH	793		May 7,2	4
			30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, I	Print)	# 315 A	h	1 2	Δ.
	<sup>2</sup> Sta	to.	CUNISTON FOR J. W. 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture /	1 000 mg	L C	ney ne	12 2083.	7
6.3	Registr		MAY 10 200	14 Seneral	19	pporks				

			For Stata	State of M	Maryland	d / Depa	artment rtificate	t of H	lealth a	and M	lental Hy		/ 11111	ICOLE
			Registrar  1. Decedent's Name (First, Middle, La	ast)			lineale	OIL	Jeani		2. Date of De	Rag. No	- 00 g	2 Time of Death
	Physic		Deanne Cole Cof	,							Month	Day		3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, gi		or)		4b. City.	Town, or	Location	of Death	May 9		County of Deat	9:25p M
	LXaiiii		3112 Gracefield			101	Silve						ntgomer	
	Funeral		5. Social Security Number 6.	Sex 7.7	Age (In yrs. la		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi	rth		thplace (State or Foreign ountry)
	Director		487 18 5200	1 ☐ M 2 🛣 F	85	Yrs.	World	Days	Hours	MIII.	May 7	191	9 Miss	Bouri
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Limits
	Maryl f sho	ŏ	Maryland Montgo	nerv		lver S								1 ☐ Yes 2 ☑ No
	7.28e	rec	10e. Street and Number	псту		LVEL	10f. Zip					10g. Citi	zen of What Co	ountry?
	h with	D	3112 Gracefield 1	Road, Parl	cview #	#101	20	904					ISA	,
	deat	ner	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S				spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame	
9	or It	F	1 ☐ Never Married 2 ☐ Married	1 Tes 2			rres,speci 1 □ Yes 2		Specify:	i, Puerto	Hican, etc.)		Black, White	e, etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Store than "natural", or Items 23a or 28e-f show event, the Modical Exerting roust be routhed at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates	:								Specify:	White
5	"nat	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	ient's Usual kind of work DO NOT use	k done d	urina mos	t of worki	ng	16b. Ki	nd of Business/	Industry
12	withi ene. than	m C	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Secre		a reureu,	,			Non	nwofit (	) no d d d
9	filed Hygi other		17. Father's Name (First, Middle, Last	")		beere	cary		18. Mothe	r's Name	(First, Middle			rganizations
<u>a</u>	ild be fental rked ic ev	To Be	Otto Wesley Burk	C							uise Co			
Maryland	4.2 should be filed within hand Mental Hygiene. 7 is marked other than "rtraumatic event, II a Ma.	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (	(Street a					Town, State, 2	Tip Code)
	and 2 salth n 27 i		David P. Coffin	'Husband		3112	Grace	fiel	d Ro	ad, Pa	arkview	#101	Silver	20904 Spring, MD
ore	1 2 2 2 7 V		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Bamayal from Stat		netery, cren	sition (Nami	e of			ate		cation - City or	
Ĕ	Page ment c ant: If ury or		*4 □Donation 5 □Other (Speci		9	ropol:				мау - 20	04	llexa	ndria.	Virginia
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic espace.		21. Signature of Funeral Service Lice	nsee		22 F	Name and	Addres	s of Facility	lins	Funera	1 Ho	me, Inc	
_	0.0 ± € 0		Mully and	/ wully		130	U Univ	vers	ity B.	LVd.W	.,Silve	rSpr	ing, Mar	yland 20901
			234. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Lung	Cance	r							-	Onset and Death
	/Medical Examiner	-	Tosulary in dealin	Due to (or a	s a conseque	nce of):								
		<u>ارة</u>	Sequentially list conditions,	b. Due to (or a	s a conseque	ince of):								
	rted rnsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- 30 10 (01 0									- 1	
Ć,	exect n and ial-tra	Еха	that initiated events resulting in death) Last	C. Due to (or a	s a conseque	nce of):								
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dlcai	(	d										
9	rtifica ng ph as th	Ved	15-5-11-5											
Вох	death certifica attending ph d for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1☐Live birth			Ectopic preg	nnancy				2	3d. Date of deliv	very
	at the dea by the at tached fo	sici	in the past 12 months? 1  Yes 2 No	4 ☐ Pregnant a			Other (spec						Month	Day Year
P.O	that the	Ph	9 Unknown								T			
ds,	ires tha signed I be de	þ	Part II. Other significant conditions of Chronic Lower		but not resulti	ing in the un	derlying cau	use giver	n in Part I.					the cause of death?
Ö	v requir	etec	ONIONIC LOWEL	neg Euema							'  '	es 218	JN0 3 Pro	bably 4 Unknown
3ec	as a	Completed									24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
a		င္ပ	05 W								1 Yes	med? 2 ∰ No	death?	2⊠ No
₹	Physicien: 'this certifica	8	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:				0.4			(Check only o			
Division of Vital Records,	g Physter this neral di	n: To	27. Manner of Death	28a. Date of Inj (Month, Da	ent 2□EF ury 28	8b. Time of	-	c. Injury a	at UNUI		ie 5 ⊠ Resid 8d. Describe h		Other (Speci	(fy)
<u>o</u>	별수호를	atlo	1 ¬Natural 5 □ Pending 2 □ Accident investigation		ay Year)	Injury	м	Work?	o' es 2.⊟N			,,		
vis	of or Attend after death Director: / d in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At home	e, farm, stre	et, factory, d	office		2	8f. Location (S	treet and	Number or Run	al Route Number,
ā	s after of in the	Cert	Tomoro	bullding, e	tc. (Specify)						City or Tow	n, State)		
	Hospitel 24 hours a Funerel L tely filled		29a. Certifier 1 To Certifying Ph	ysician: To the best niner: On the basis	of my knowle	edge, death	occurred at	the time	, date and	place, ar	nd due to the d	ause(s) a	and manner as s	stated.
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	/	and manner s	tated.	and or my				1 occurre	at the time, c	ate and p	olace, and due t	o the cause(s)
	S o o	~	29b. Signature and title of certifier	Ce	<b>\</b>	10		License			2		signed (Month,	_ '
	6			Mumai		レ		152	4			Ma	4,10,	2004
			30. Name and address of person who					_						
	Sta	te.	Loveen: Puthumana ;	32. Regist	. 10 Gra rar's Signatur	ecerie	.40			r Spi	ring, M	ary1	and 209	04
	Registr		MAY 11 2	004	war	19	200	مركاري	j					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Ment Certificate of Death

tal Hygiene	2	0	n	1	
Reg. No.	-010	~	10	9	

16816

permit. Pages 1 and Department of Health Important: If item 27 any injury or other to

Pnysician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		1. Decedent's Nam	e (First, Middle,	Last)						2. Date of D Month		, ,	'ear	3. Time of	f Death
icia dica		John	Edward	d Costilo	WC					APRII	」 29	, 200	4	2035	р M
nine		4a. Facility Name (i		give street and numb SPITAL	er)		4b. City, Town, CUMBE		of Death		4c.	County of AL	Death LEG/	ANY	
al		5. Social Security N	lumber 6	5. Sex 7. 1 XM 2 ☐ F	Age (In yrs. Ia		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of B (Month, D	ay, Year)	9	. Birthpl Count	ace (State o	or Foreign
or		213-80-8 Usual Residence of		102.	4.5	Yrs.				Apr 1	0 19	59 V	Vest	. Vir	gini
	ŀ	10a. State	10b. County		10c. City,	Town or Lo	cation						10	d. Inside Ci	ity Limits
- A	to	MD	Allega	any		Bart	on							1 □Xes	2 No
	Funeral Director	10e. Street and Nu					10f. Zip Code				_	zen of Wha		-	
	aiD	19218	Legisla	ative Rd			2152	1			Unit	ed S	Stat	ces	
	ner	11. Marital Status		12. Was Decede Armed Force	s?	. 13.	Was Decedent of If Yes, specify Cul	Hispanic Original	gin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - Black,	America White, e		
١,	þ	1 ☐ Never Marr 3 ☐ Widowed	ied 2 XMarne 4 □ Divorced	d 1 □Yes 2] If Yes, Give Year or Date			1 □ Yes 2 □XNo	Specify:				Specify: V	√hit	ce	
	etec	(Spec	15. Decedent's cify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	t of workir	ng	16b. Ki	nd of Busir	ness/Ind	ustry	
ľ	Completed	Elementary/Seco		College (1-4	or 5+)		DO NOT use retire rmaker	d)			Wes	stvac	20		
		17. Father's Name	(Eimt Middle La	Unknown		rape	IMAKEL	19 Motho	e's Nama	(First, Middle					
	Be	Edward								Hacke	,	Surname)			
1	္	19a. Informant's N				19h Maili	ng Address (Stree					Town St	ate Zin	Code)	
l		Heidi C					8 Legis								
l		20a. Method of Dis		W/ WIIC	20b. Pla	ce of Dispo	sition (Name of			ate	*	cation - Cit			
ı		ty Burial 2	☐ Cremation 3	B □Removal from Stancify)	100	-	natory or other pla	1	Marr	E 04	Mos	scow,	БМ		
ŀ	İ	21. Signature of Fl			ML.		Cemete 2. Name and Addr								
		1/1/2	11/1/2				Name and Addr				Chi	ırch	St		
r		23a. Part1. Enter t	he disease, or co	omplications that cau-	sed the death.	Do not ent	esternr er the mode of dy	ng, such as	cardiac o	r respiratory	arrest,			Approximate	
Į		Immediate Cause	(Final									1		Interval Bet Onset and I	
ı		disease or condition resulting in death)	on .	a. Due to (or	as a conseque	ende if);	man.	V	yu	VCC		1	-		
ı	И			court	2 terro	mbot	andia ic oech	WOLL	cont	nan	an	ter	4		
۱	ner	Sequentially list co if any, leading to in cause. Enter Under	nditions, nmediate	Due to (or	as a conseque	ence of):				1	3	_	J		
1	Examiner	Cause (Disease or that initiated events	injury s	c											
		resulting in death)	Last	Due to (or	as a conseque	ence of):									
	lica			d							_		_		
	cian/Medicai	IF FEMALE:		220 If you guitage	no of program										
	ian/	23b. Was deceden in the past 12			2 Fetal c	leath 3[	Ectopic pregnand	у			2	3d. Date o Month		-	/ear
		1 ☐ Yes 2 [ 9 ☐ Unknown	□No	4□Pregnan 9□Unknowi	tat time of dea n	ith 5	Other (specify) _								
i	/ Physi			s contributing to deat	h but not result	ting in the u	nderlying cause o	ven in Part I.		23e. Did	tobacco u	se contribu	ite to the	cause of d	leath?
	d b	<b>J</b>		J -= -340			, , 9					at the same of the		ibly 4 □U	
	Completed									04-146-					en tetele
ľ	d w									24a. Was		24b. Wei	re autop r to com th?	sy findings a pletion of ca	available ause of
										1 Yes	2 🗆 No	12	Yes 2	2□ No	
1	Be	25. Was case refer examiner?		Hospital:			0:	200		(Check only					
P	2	1 XYes 2 ☐ 27. Manner of Deat		28a. Date of I		R/Outpatier 28b. Time of				ne 5 ☐ Res 8d. Describe			Specify)		
	E C	Natural	5 Pending investigat	(Month,	Day Year)	Injury	Wo	rk? Yes 2 □ l		ou. Describe	non injury	occurrog			
	ica	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be 290 Blace of	Injury - At hom	ne farm str	eet, factory, office	,		8f. Location	Street and	l Number o	or Rural	Route Numi	her
:	Certification:	4  Homicide	determine		etc. (Specify)		,,			City or To	wn, State)				
		29a. Certifier (Check only	1 ☐ Certifying	Physician: To the be	st of my know	ledge, deatl	occurred at the t	me, date and	d place, a	nd due to the	cause(s)	and manne	er as sta	ted.	)
	Medical	one)	7. A.	and manner	stated.					1					, 
	<	29b. Signature and	THE CONTINUE	1/N	1		29c. Licen	c.M.E			APF	signed (A RIL 1		ay, Year) 2004	
			11 / 170		1		0.				4 24 1				
			1001	X /	3										
		30. Name and addr	ress of person wh	no completed cause of				R=1+	imor	o Mar	wl and	1 2120	<b></b>		
A STATE OF S		5.7	2. Ho	SCIAN	11	1 Pen	Street	, Balt	imor	e, Mar	yland	1 2120	01		
tat tra	•	30. Name and addr	2. Ho	SCIAN	11	1 Pen		, Balt	imor	e, Mar	yland	1 2120	01		

			1 - State Registrar		aryland / Depa		ealth and I	-	ne 2004	16817
	Physici		Decedent's Name (First, Middle, La     ARTHUR CORN			-	-	2. Date of Death Month	Day Year	3. Time of Death 1306 M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of Death	
			PENTINSULA REG 5. Social Security Number 6. S	IONAL MED	ICAL CENTER ge (In yrs. last birthday)	SALIS If Under 1 Year	BURY If Under 24 Hrs.	8. Date of Birth	WICOMIZ 9. Birthold	ace (State or Foreign
	Funeral Director		216-18-8776	<b>∑</b> M 2□F	84 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ear) Count	ny)
	land land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				d. Inside City Limits
	the Marylar 28e-f show	ctor	MD WICOMIC	0	QUANTICO	)				1 ☐ Yes 2 🙀 No
	with the	Funeral Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Count	ry?
	after death w or items 23a	neral	22870 NANTICOK  11. Marital Status	E ROAD  12. Was Decedent Armed Forces	Ever in U.S. 13.	21856 Vas Decedent of H f Yes, specify Cuba			14. Race - America	
900	d within 72 hours after death with the Maryland jene r then "natural", or items 23a or 28e-f show the Medical Evand ar must be indified at	þ	1 ☐ Never Married	1 XYes 2 If Yes, Give Year or Dates:	No	Tes, specily coba	Specify:	o rican, etc.)	Specify: BLA	
21215-0036	n 72 hours "natural", edical Eva	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during most of wor	king 16b	b. Kind of Business/Inde	ustry
212	73 75 - +4	omo:	Elementary/Secondary (0-12)	College (1-4or	5+)	FER STA	•	WI	ICOMICO C	10-
und	should be filed withir nd Mental Hygiene. marked other then imatic event, the M	Be	17. Father's Name (First, Middle, Last					ne (First, Middle, Maid	den Sumame)	
Maryland	s 1 and 2 should be filed of Health and Mental Hyg item 27 Is marked othe other treumatic event.	2	ISSAC WHITE C  19a, Informant's Name/Relationship (		19b. Mailir	g Address (Street	VIOLA A and Number or Ru		ty or Town, State, Zip (	Code)
	ss 1 and 2 s of Health ar item 27 ls cother treu		THELMA CORNISH	• •	22870	NANTIC			CO,MD 218	
Baltimore,	iges 1 and of He	-	20a. Method of Disposition 1 Xurial 2 Cremation 3			natory or other plac			. Location - City or Tov	
Iltim	Par ent ury		* 4 □Donation 5 □ Other (Special Service Lice)			. Name and Addres	-	15/04 QL	JANTICO, M	D
Ba	permit. Departimports any inj		23a. Part1. Elter the sease, or com	3400				HOME PO		
760,	beath certificate be executed attending physician and attending physician and for use as the burial-transit	lical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Uncease or highly that initiated events resulting in death) Last	b. Due to (or as	s a consequence of):					Interval Between Onset and Death
.O. Box 68	The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
rds, P	v requires that the death been signed by the atte should be detached for	þ	Part II. Other significant conditions	contributing to death I	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	couse contribute to the	
Records,	The law rec cate has bee page 2 shot	Completed						24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
Vital		BeC	25. Was case referred to medical examiner?			T		th (Check only one)	107 12103 2	
of	Phys this ral di	2	1 ☑ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpati		t 3 DOA Other	4   Nursing H	ome 5 Residence	e 6 ⊡Other (Specify)	
ion	Attending I r death. ector: After by the funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da		Worl	k? Yes 2 □ No		.,,	
Division	el or Atte s after de l Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm, str tc. (Specify)	eet, factory, office		28f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicel Example	nysician: To the best miner: On the basis and manner s	of my knowledge, death of examination and/or in- tated.	occurred at the tin restigation, in my o	ne, date and place pinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as sta and place, and due to t	ted. the cause(s)
	To th To th	M	29b. Signature and title of certifier	1 1		29c. License	e number	29d.	Date signed (Month, D	ay, Year)
	1		Phy one	min	death (from SS-) (T	102	0112		77/84	
	SIM		30. Name and address of person who Dennis Chadl	ricki 10	OE. Car	011 5+	Sali	sbury M	D 21801	
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 1 2	32. Regist	rar's Signature	Spark	2			

		-	1 - For State Registrar AMEND#8penFH5/1	State of Maryla	and / Depa	artment of H	lealth an Death	nd Mental F	lygiene Reg. No	200	4 16818
* * · · ·	hvalai		Decedent's Name (First, Middle, Last)					2. Date of Month	Day		3. Time of Death
	hysicia /Medic	al	Cornelia VanAntwerp		-	4b. City, Town, o	r Location of C	May		004 County of Dea	9:55am <sup>M</sup>
E	Examin	er	333 Russell Avenue			Gaither		56411		Montgom	70
Fu	ineral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)		If Under 24	Min. (Month,	Birth Day, Year)	1904 9. Bij	rthplece (State or Foreign country)
	ector		139-38-3553	100 ± 100	) Yrs.			Jan.	19, <del>2</del>		pany, NewYork
and	M M		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
Магу	Hed a	to	Maryland Montgomery	y Ga	ithersb	urg					1 X Yes 2 □ No
th the	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What C	ountry?
ath w	238 unit	rai	333 Russell Avenue		12	20877	lienanie Origin	2 (Specify Ves or		nited S	
ter de	Them.	Funeral	11. Marital Status  1 Never Married 2 Married	<ol> <li>Was Decedent Ever in Armed Forces?</li> <li>1 ☐ Yes 2 ♣No</li> </ol>		Was Decedent of H II Yes, specify Cuba		Puerto Rican, etc.)	110	Black, Wh	
hours at	E. o.	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:				ite
<b>7</b> 2 hc	dical	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most o	f working	16b. K	ind of Business	s/Industry
within ane.	then he Ma	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	1	emaker	27			Own Ho	me
Yiärid XIXIS-UUSO uuld be liled within 72 hours after death with the Maryland Mental Hygiene.	ent,	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Mid	dle, Maiden	Sumame)	
ylarid buld be file Mental Hy	rked tic ev	To B	Thomas Irwin VanAn	twerp				e Scudde			
sh da	EE		19a. Informant's Name/Relationship (Type			ng Address (Street					Zip Code)
and and lealth	m 27		Suzanne Davis Tull 20a. Method of Disposition		b. Place of Disp	1 S. Glen		Potomac		20854 ocation - City o	r Town, Slate
ages ant of	t: If It		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		matory or other place itan Crem		5/10/20	04 A	lexandr	ia, Virginia
Baltimor permit Pages Department of	Important: If its any in ury or ot once		21. Signature of Funeral Service Licenses		2	2. Name and Addre	ss of Facility	DeVol F			, ,
ă ăa	E E S		Yoland A.W.	Wat -		10 East D Gaithersb			-		T
			23a. Part1. Enter the distance or complications, or healt failure. I st only one	ation, that caused the decay e on each line.	leath. Do not er	ter the mode of dyir	ng, such as ca	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	sician edical	. 1	Immediate Cause (Final disease or condition resulting in death)	Congestive Due to (or as a con		Failure					5 Days
	miner			Aortic Ste							Years
	er the	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a con							
<b>60,</b> be executed	and Ftrans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a con	sequence of);						
/60,	attending physician and for use as the burial-transit	calE	d.	(							
	g phy: as the	edi									
Box	lendin r use	an/N	23b. Was decedent pregnant	ic. If yes, outcome of pre	Fetal death 3	□Ectopic pregnanc	у			23d. Date of d	elivery Day Year
I Records, P.O. Box 68 The law requires that the death certifica	by the at tached fo	Physician/M	in the past 12 months? 1 ☐ Yes 2X No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify) _			-		
that #	igned by be detac	/ Ph	Part II. Other significant conditions cont	ributing to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. C	id tobacco	use contribute	to the cause of death?
rds	n sign uld be	q pa	Alzheimers, Dement	ia				_   1	☐ Yes 2	<b>™</b> No 3 □ F	Probably 4 Unknown
<b>Vital Records,</b> sicien: The law requires t	s been si	Completed by						а	Vas an utopsy	24b. Were a	autopsy findings available completion of cause of
	page 2	Com							erformed? s 2 🔯 No	death?	es 2 🗆 No
of Vita	this certificate al director, pag	Be	25. Was case referred to medical examiner?	ospital:	0	oti	200	ol Death (Check or sing Home 5 🔀 F		6 Other (Sn	acción)
o g	ar this eral di	n: To	1 ☐ Yes 2 🖾 No  27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time tnjury		ry ai			iry occurred	ocny/
Vision Attending	tor: After	atio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	(MORITI, Day 1 ea	a) anjury		Yes 2 N	0			
Division of lor Attending Physical Attending Physical Attending Physical Physical Attending Physical Attending Physical Attending Physical Attending Physical Attending Physical Attending Physical Attending Physical Attending Physical Phy		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - a building, etc. (Sp		treet, factory, office			n (Street a Town, Stat		Rural Route Number,
Hospital of hours a	filled i		29a. Certifier 1X Certifying Phys	ician: To the best of my	knowledge, dea	ith occurred at the ti	me, date and	place, and due to	the cause(s	and manner	as stated.
e Hos	To the Funeral Completely filled	Medical	(Check-only 2 Madical Exemin	er: On the basis of examination and manner stated.	mination and/or	nvestigation, in my	opinion, death	occurred at the ti	me, date an	d place, and di	ue to the cause(s)
		ž	29b. Signature and title of certifier	0 00 0	1	29c. Licen	se number		29d. Da	ate signed (Moi	nth, Day, Year)
	8		John 16	- Muli	well h	AI) D192	94		May	10. 20	04
			30. Name ar dress of person who con John R. Melnick, M				ershur	e, MD 20	877		
100	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S				21 110 20			
9	Regist	rar	MAY 11 200	4 Janeres	7	Spark					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) May 7, Day 2004 6:45 **Physician** Рм Joan E. Dawson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 22, 19 Birthplace (State or Foreign Country) 7 Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 79 Missouri 513-16-7920 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury po-10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 1 □ Yes 212 No Completed by Funeral Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 20814 5215 West Cedar Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Tes 2⊠ No Specify. Specify: 31X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John C. Power Flora Harding 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah A. Dawson/Daughter 5111 Duvall Drive, Bethesda, Maryland 20816 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 9, 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 2004Bethesda, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase, Inc. 21. Signatura Nobert A. Pumphrey Funeral Home/ Chase, 1 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia Days /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner transit death certificate be executed and Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical thet as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 € No P.O. 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Urinary Tract Infection Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1

∫ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes \_ 2 ☑ No 2 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Diractor: After thi
completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide t 🖾 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe amon Min D32332 May 7, 2004 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, M.D. 9801 Georgia Avenue, Silver Spring, Maryland 20902 Y 1 0 2004 32. Pegistrar's Signature State Registrar

			for State Registrer	State of N	Maryland / De C	partment of e <i>rtificate of</i>		and Mental Hy	gienez Reg. No.	004	16820
			1. Decedent's Name (First, Middle,	Last)				2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medio		Sandro	de Tommas	50			May		2004	11:00 A M
1	Examin		4a. Facility Name (If not institution,	give street and number	ər)	4b. City, Town,	or Location o	of Death	4c. C	ounty of Deati	h
			8500 Buckhannor		A no (la una la sa binda d	Potoma		24 Hrs   0 Date of D	Mo	ntgome	ry
	Funeral Director			6. Sex 1½ M 2□F	Age (In yrs. last birthda Yrs.	Months Days		Min. (Month, D	ay, Year)	Co	nplace (State or Foreign untry)
L			220-29-0542 Usual Residence of Decedent		61			Nov.14,	1942	Ital	у
	yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	a-fsl	ctor	Maryland Montge	omery	Poto	mac					1 ☐ Yes 2 反 No
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	untry?
	in 72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show odical Examiner must be notified at		8500 Buckhannon			2085			Ital		
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	<ol><li>Was Decedent of If Yes, specify Cu</li></ol>	Hispanic Orig pan, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	0- 14	Race - Amei Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ★ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2 Tes 1 Tes 2 Tes 1 Tes 2 Tes 1 Tes 2 T		1 ☐ Yes 2 🙀 No	Specify:		s	pecify:	
응	tura stura		15. Decedent		16a. De	cedent's Usual Occi	pation		16b. Kind	Whi of Business/l	
15	- 20	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4c	(Gi	ve kind of work done  DO NOT use retire	during most	of working			,
212	M the second	E O	clestiestary/Secondary (0-12)	4		plomat			Forei	gn Gov	ernment
b	ba filed ital Hygie id othar evant, III	BeC	17. Father's Name (First, Middle, L	ast)			18. Mothe	r's Name (First, Middle			
/lai	uld b Menta	2	Salvatore de '	Commaso			Ros	sina Bern	ardi		
Maryland 21215-0036	permit. Pagas 1 and 2 should ba fill Department of Health and Mental H Important: If item 27 is marked ott any injury op-other traumatic even once.		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	ailing Address (Stree	t and Numbe	r or Rural Route Numb	per, City or 1	Town, State, Z	lip Code)
	and ealth m 27		Adriana de Tomma	aso Wif		Buckhann	on Dri			Maryla	
ore	H ita		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from Sta	cemetery, c	position (Name of rematory or other pl.	ace)	Date	20c. Loca	tion - City or	Town, State
Ë	Pag iment tant: jury		* 4 □ Donation 5 □ Other (Sp	ecify)	Gate of	Cemetery	N	May 10,2004	Silv	er Spr	ing,MD
Baltimore,	ermit Depar Inpor Ince		21. Signature of Funeral Service L	io Tan	F	22. Name and Addi	ess of Facility Colli	ns Funeral	Home	. Inc.	
	0.0 = 0 O		TO SHE C.	Onk	5	00 Univer	sity E	Blvd.,W.,Si	lver	Spring	
			23a. Part1. Erfer the disease, or shock, or heart ailure. List o	complications that caus only one cause on each	sed the death. Do not on line.	enter the mode of dy	ing, such as	cardiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
a:	Physician		Immediate Cause (Final disease or condition resulting in death)	_	mphoma						Chronic
	/Medical Examiner		roogaling in additing	Due to (or a	as a consequence of):						
		еľ	Sequentially list conditions,	b. — Due to (or a	as a consequence of):		<u> </u>				
	nsit	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,						
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or a	as a consequence of):						
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai I		d							
9	tificate I g physi as the b	(d)									
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		3 □Ectopic pregnan	24		23	d. Date of deli	very
	deat	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 Other (specify)	·y		li)	Month	Day Year
P.0	at the de by the	h	9 🗆 Unknown								
	es that igned by be deta	by	Part II. Other significant condition	s contributing to death	n but not resulting in the	underlying cause g	ven in Part I.				the cause of death?
Records,	n requires baan sign should be	ompieted						1	Yes 2 🙀	No 3 □ Pro	bbably 4 Unknown
ec	aw is b	pje						24a. Was	psy	prior to c	topsy findings available ompletion of cause of
<u>=</u>	The trate has	Con						1 Tyes	ormed? 2 <u>⊊</u> No	death?	2 🗆 No
Vital	certifical	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check only	one)		
of	Phys this al dir	7	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 🗆 Inpa		IGHT SE DOA		rsing Home 5 Res 28d. Describe			ify)
n	e fe	ion	1 XNatural 5 ☐ Pending		Day Year) Injur	y Wo	nyat ork? ]Yes 2.∐N		now injury c	occurred	
18	an or:	ical	2 Accident investig 3 Suicide 6 Could n	ot be 300 Place of	Injury - At home, farm,				Street and I	Number or Rui	ral Route Number,
Division	al or Attandii s after death. al Diractor: A ed in by the fu	Certification:	4  Homicide determine	building,	etc. (Specify)	on out, raciony, cirioc		City or To	wn, State)		
	Hospital 14 hours a Funaral I		29a. Certifier 1X Certifying	Physicien: To the be	st of my knowledge, de	ath occurred at the	ime, date and	d place, and due to the	cause(s) ar	nd manner as	stated.
	a Ho 124 h na Fui letely	edicai	(Check only 2 Medical E one)	xeminer: On the basis and manner	of examination and/or stated.	investigation, in my	opinion, deat	h occurred at the time,	date and pl	ace, and due	to the cause(s)
	To tha Hospital or Atti within 24 hours after de To tha Funaral Diracto completely filled in by ti	Me	29b. Signature and little of certifier	Er.	Δ .	29c. Licer	se number		29d. Date s	signed (Month	, Day, Year)
			· //41/V	M in	rin ,	5	3177		Yau -	7. 2004	
	10		30. Name d addre of person v	no completed cause o	f death (Item 23a) (Typ				- Confirm	2004	
_			John M. Wallma			dical Cen	ter Dr	ive #300	Rocky	ille,Mr	20850
	Sta	100	31. Date filed (Month, Day, Year)		strar's Signature						
.00	Registr	ar	MAY 11	2004 1	and p	Spark.					9

			for Stete Registrar	State	of Mary	land / Dep <i>Ce</i>	artment rtificate			and M		giene Reg. No. 2	004	16821
	Physici /Medic	cal	Decedent's Name (First, Midd Angela M. Dit     Angela M. Dit     Angela M. Dit	chey	umber)		4b. City, To	OWN Or	Location	f Doath	2. Date of Da Month May	Day 8	Year 2004 unty of Death	3. Time of Death 10:50 p M
	Examir	ner	Montgomery Ge:				Olney		Location o	Death			ntgomer	<b>*</b> V/
	Funeral		5. Social Security Number	6. Sex		yrs. last birthday,	If Under 1	Year	If Under 2		8. Date of Birt	h		place (State or Foreign
	Director		168-20-6862	1 ☐ M 2 🖾 F		77 Yrs.	Months	Days	Hours	Min.	Sep 2,	1926	Cour	PA
	and w		Usual Residence of Decedent  10a. State 10b. Count	,	100	c. City, Town or L	ocation							24 1 2 2 2 2 2
	/anyla	ō	MD Montg			Silver S							'	0d. Inside City Limits 1 ☐ Yes 2 🔯 No
	the the 286-	rect	10e. Street and Number				10f. Zip C	Code				10a Citizen	of What Cour	
	3a or	0	15115 Snow Ma	ss Court			,	2090	6			USA	or vende cour	my:
	deatl	Funeral Director	11. Marital Status	12. Was De Armed F	cedent Ever	in U.S. 13.	Was Decede	nt of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	- 14. [	Race - Americ	
36	or its		1 Never Married 2 Mar	ried 1 ☐ Yes If Yes, G	2 ☑ No live	1	1 ☐ Yes 21		Specify:	, Puerto i	Hican, etc.)		Black, White,	
Ö	hours tural',	ed by	3 ☑ Widowed 4 ☐ Divorced	Year or	Dates:				1 4				ocify: Whi	
21215-0036	in 72 "nai redic	Completed	(Specify only highe	nt's Education est grade completed		16a, Dece (Give	dent's Usual kind of work DO NOT use	done du	tion <i>uri</i> ng most	of worki	ng	16b. Kind o	f Business/Inc	dustry
212	l with liene.	mo	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		maker					Own	Home	
פ	e filed al Hyg othe vent,	Be C	17. Father's Name (First, Middle,	Last)					18. Mother	r's Name	(First, Middle,			
<u>ya</u>	Menta Menta arkad	To	Nicholas Regn	ery					Maı	y St	telle			
Jar	2 sho		19a. Informant's Name/Relations								l Route Numbe			Code)
e)	1 and lealth sm 27 ther t		Michele Ditche 20a Method of Disposition	ey/Daught		7931 Ob. Place of Dispo			m Lar		Severn,			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show minimportent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic avent, the Modical Examiner must be notified at once.		1√□ Burial 2 □ Cremation		State G	cemetery cre	natory or other	er place,	N	lay 1	ate L 2		on - City or To	
Ħ	artme orten		<ul> <li>4 □ Donation 5 □ Other (S</li> <li>21. Signature of Funeral Service</li> </ul>			Ce	metery	Z Address	of Facility		2004		r Spri	
Ba	Dep Imp		1 Willia	I Bu										eral Home MD 20901
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that	caused the								pring,	Approximate
	Physician		Immediate Cause (Final disease or condition	only one cause on	Š.	TROK	E						4	Interval Between Onset and Beath
	/Medical Examiner		resulting in death)	Due to	(or as a cor	nsequence of):							- /,	IUDIA
k.	LAGITITICI	-	Sequentially list conditions, if any, leading to immediate	b. — Due te	(0.000000000000000000000000000000000000									
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Ć,	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a cor	nsequence of):				-				
8760,	ysicia	dlcal												
9	ntifica ng ph	Med	IF FEMALE:											
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2 🔲	Fetal death 3	Ectopic preg	nancy					Date of deliver	'
	at the de by the a tached f	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time nown	of death 5	Other (spec	ify)					Month	Day Year
م	The law requires that the te has been signed by the bage 2 should be detached.		Part II. Other significant conditi	ons contributing to c	leath but not	resulting in the u	nderlying cau	se given	in Part I.		23e. Did to	bacco use co	ontribute to the	e cause of death?
rds	quires n sigr	d by	1// 1/7/58	7 EJ V	hec	LITU.	1				1 🗆 Y	es 2 🗆 No	3 ☐ Proba	ably 4 Allownown
000	s been si	olete				,					24a. Was a	an 24	b. Were auton	sy findings available
Ä	The lav	Completed									autops	sy	prior to con death?	apletion of cause of
Vital Records,	siclen: Th certificate rector, pag	Bec	25. Was case reterred to medica examiner?						26. Place	of Death	1 ☐ Yes (Check only on		1 185	2
7	Phyeic this co	ဥ	1 ☐ Yes 2 ☐ ¥6			2 ER/Outpatien		Other	4 🗆 1901:	sing Hom	ne 5 ☐ Reside	ence 6 🗆 C	Other (Specify,	)
Division of	ding F	lon	27. Manner of Death 1 ■ Pendir	9	of Injury Ith, Day Yea	z) 28b. Time of Injury		. Injury a Work?			8d. Describe he	ow injury occ	urred	
S	death ctor: , the	lcat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	e of Injune	At home, farm, str	M factors o		s 2 🗆 N		9f Location (C	traat and Nu	mhor or Com	Route Number.
2	after after I Direct	Certification;	4 ☐ Homicide determ	build	ing, etc. (Sp	necify)	ser, ractory, o	IIICO		-	City or Town	n, State)	mper or Hurar	Houte Number,
	ospite hours inerel y filled		29a. Certifier 1 Certifyir	ng Physicien: To the	e best of my	knowledge, death	occurred at	the time	, date and	place, ar	nd due to the ca	ause(s) and	manner as sta	ited.
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certification the funerel director, and the funeral director, completely filled in by the funeral director,	Medical	(Check only 2 Medical one)	exeminer: On the b	pasis of examiner stated.	nination and/or inv	estigation, in	my opir	nion, death	occurre	d at the time, d	ate and place	e, and due to	the cause(s)
	o with a	Σ	29b. Signature and title of certifie	2		1444	29c, L	icense r	number	`	2	9d. Date sign	ned (Month, D	Day, Year)
	5	-	10//	1		wy)	1	70	73/		/	NIY	1,4	707
			30. Name and address of person	who completed cau	of death (	(Item 23a) (Type,	Print)	11	7 1	P	S/L .S	PRIM	16.11	11
	Sta	te	31. Date filed (Month, Day, Year)		ogistrar's S	ignature /	NIV	44	( D)	1	1/6,3	////	7	20x6
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			1 - For State of Maryland State of Maryland	/ Depa	artment <i>tificate</i>	of He	alth ai <i>eath</i>	nd Mei	ntal Hyg	giene Reg. No	20	04	16822
			Decedent's Name (First, Middle, Last)					2.	Date of Dea Month	ath Da	v 1	reer	3. Time of Death
	Physicia /Medic		Charles T. Duncan					1	May 4,	2	004	1001	7:00 A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, T	own, or L	ocation of	Death			. County of		
			1362 Myrtle Avenue		Anna If Under	apoli	S If Under 2	4 Hrs   0	Date of Birt		nne A		
	Funeral		5. Social Security Number 579-40-9876 6. Sex 7. Age (In yrs. las	Yrs.			Hours	Min.	Date of Birt (Month, Da	V. Year)	924 1	9. Birinpi Couni	ace (State or Foreign ry) .ngton, DC
ì.	Director		Usuel Residence of Decedent						CC. 31	. , .	327 N	asiii	ingcon, Do
	land ow			Town or Lo	cation							10	Od. Inside City Limits
	Mary Fiet	ţ	Maryland Anne Arundel An	napo.	lis								1 X Yes 2 ☐ No
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	23a o	aiD	1362 Myrtle Avenue		21	1403				Un	ited		
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 194	13.	Was Decede f Yes, speci	ent of Hisp rfy Cuban,	manic Origi Mexican,	in? (Specif Puerto Ric	y Yes or No an, etc.)		14. Race Black	- America White, e	
2	or it	J.	1 Never Married 2 Marned If Yes, Give 105		1 Yes 2	XNo	Specity:				Specify:	B1a	ick
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3	filed Hygi other		17. Father's Name (First, Middle, Last)			1	8. Mother	's Name (F	First, Middle,	Maider	Sumame	)	
yland	ld be lental ked ic ev	To Be	Charles Tignor				Glady	ys Ja	ckson				
	shou and M mar umat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address	(Street an	d Number	or Rural F	Route Numbe	er, City	or Town, S	tate, Zip	Code)
Mar	and 2 alth a 127 ic		Pamela T. Duncan (wife)				e. /		olis,				.403
<u>e</u>	of He		cen	netery, crer	nsition (Nam matory or ot	her place)	i.	Date		20c. L	ocation - C	city or To	wn, Stete
altimore,	Page ant: I		'4 □ Donation 5 □ Other (Specify) Che		ake Cı								Maryland
all	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural," or items 23e or 28e-f show empty injury or other traumatic event, fre Medical Examinar must be invitible at an once.		21. Signature of Funeral Service Licensee						ire Fu				
מ	80598		Indre Thompson						.W., W		ingto	n, I	
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode	e of dying,	such as c	ardiac or r	espiratory a	rest.			Approximate Interval Between Onset and Death
) _	Physician		Immediate Cause (Final disease or condition a Chronic (	Obstr	uctive	Pul	mona	ry Di	sease				5 years
	/Medical Examiner		resulting in death)  Due to (or as a conseque	nce of):									
	LAGITITICI	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence)	nce of):									
	pe psit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nice oi).									
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2/60	certificate be executed uding physician and use as the burial-transit	Ilcai E											
/89	licate phys		0.										
ROX	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		75						23d. Date	of delive	ry
ň	death e atten ed for u	icia	in the past 12 months?  4 Pregnant at time of dea		□Ectopic pro □ Other (spo						Mon	th	Day Year
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	law requires that the de as been signed by the a 2 should be detached t	by P	Part II. Other significant conditions contributing to death but not result	ting in the u	inderlying ca	ause giver	in Part I.						e cause of death?
Records,	w require been sig								10	Yes 2	2 □ No :	3   Prob	ably 4 Sunknown
ပ္တ	law ras be	pie							24a. Was auto	SV	24b. W	ere auto	psy findings available inpletion of cause of
	The ate h page	Completed							1 Yes	rmed? 2 N	0 1	eath?	2□ No
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$\leq$	or All	ertif	4 Homicide determined building, etc. (Specify)	110, 141111, 31	reet, ractory	, onice			City or To				,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician: To the best of my know	ledge, deal	th occurred	at the time	, date and	d place, an	d due to the	cause(	s) and mar	iner as st	ated.
	24 h Fur	edical	(Check only one)  2 Medicel Exeminer: On the basis of examination and manner stated.	on and/or in	nvestigation	, in my opi	nion, deat	h occurred	at the time,	date ar	nd place, a	nd due to	the cause(s)
	ro thin Fo thin comple	Me	29b. Signature and tytle of certifier		290	. License	number			29d. D	ate signed	(Month,	Day, Year)
1	0 1		I'Matthall		t	55	181	Cf		5	17	104	/
	4+1		30. Name and address of person who completed cause of death (Item		. Print)	1			- 1				
			Matthew J. Malta	132	Ho	lida	20	7 3	vite	2	011	MNI	Poeis 2140
		ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature of the Signat	ure 4	10	n. 2.	1						
	Regist	rar	MAY 17 2004 Dependent		10401	1000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16823 State of Maryland / Department of Health and Mental Hygiene 2 () () () Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:10 a M Helen Duncan May 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 및 F TT. 84 Mar 12, 1920 318-14-3314 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a, State 1 ☐ Yes 2 ☐ No Director Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3620 Littledale Rd. #305 20895 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education University Comptroller 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Sam T. Duncan Edith R. Marlow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Duncan Tebow/Nephew 9811 Capitol View Ave., Silver Spring, MD 20910 20b. Place of Disposition (Name of cometery crematory or other place) 20c. Location - City or Town, State May 12 20a. Method of Disposition Metropolitan 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 500 University Blvd. W. Silver Spring, mes 23a. Part1. Shert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemmorhagic Shock 48 hours disease or condition resulting in death) Due to (or as a consequence of): Ruptured Abdominal Viscus 48 hours Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): an/Medical 011 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Physici ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Completed by 0 1 🗌 Yes 2√ No 3 Probably 4 Unknown abdominal ileus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an peripheral edema, chronic autopsy performed 5 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be u<sub>a</sub> Hospital: 1 🖾 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 X Yes 2 □ No 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 St Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 - Homicide 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2. Medical Examiner: On the basis of examination and/or investigation in sure 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  $\geq$ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Name and address of person who completed cause of death (Item 23a) (Type, Print) James Weiss 8401 Connecticut Ave. Suite 203, Chevy Chase, MD 20815

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

13 2004

**Funeral** 

Director

27 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be indifficial

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Pages 1 and 2 should be fited within 72 hours after death with

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To the Funerel Director; A completely filled in by the fu

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The law requires that the death certificate be executed

Box 68760,

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Division of Vital Records, P.

Baltimore, Maryland 21215-0036

32, Registrar's Signature

		For State Registrar		laryland / De	epa	artmen tificate	t of H	lealth a	and M	ental Hygi	ene 2	004	168	324
Physicia	n	Decedent's Name (First, Middle	Last)							Date of Death     Month	Day	Year	3. Time of	Death
/Medica		Carl Redmond		Dwyer						May 6,	2004		3:15	P <sup>M</sup>
Examine	er	4a. Facility Name (If not institution,	give street and number	r)				Location of	of Death			nty of Death		
Function		Casey House 5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthd	lav)	Rock If Under		Le If Under:	24 Hrs.	8 Date of Birth		tgomer		r Fornian
Funeral Director		557-54-3777 Usual Residence of Decedent	1⊠M 2□F	88 Yrs	- /	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, June 9,	1915	Edger	lace (State of htry) ton Ka	ansas
Aaryland F show	ō	10a. State 10b. County MD Mont	gomery	10c. City, Town o		cation						1	0d. Inside Cit	
or 28a-	Funeral Director	10e. Street and Number				10f. Zip		-		10		of What Coun		
ath w	<u>a</u>	5550 Tuckerman				208						S.A.	-	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Exertit at much be routilised and once.	by Fune	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 🖫 Yes 2 ☐ If Yes, Give Year or Dates	? 1 No		Vas Deced f Yes, spec			gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		lace - Americ lack, White, cify: Wh		
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or Attending after death. Director: After in by the fune	Certification;	1 X Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no 4 Homicide determin	ation	jury - At home, farm, tc. (Specity)		М	1 🗆 Y	Yes 2□N		8f. Location (Stra City or Town,	et and Nun State)	nber or Rural	Route Numb	9 <i>r</i> ,
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3		30. Name and address of person w Charles Harrison		death (Item 23a) (Typn ncaster Mi			d Ro	ckvi1	le,	MD 20877		l	1	
State Registrar	-	31. Date filed (Month, Day, Year)  MAY 1 0 2		rar's Signature		Soa	1/2/							

			1 - For State Registrar AMEND#1perM	State of M 5/14/04,BMW,	larylan	d / Depa		of H	ealth a	and M	lental Hy	niono	200	16825
	Physici		Decedent's Name (First, Middle, I  Elaine M.			DYM	1				2. Date of De Month May	ath Day Q	Year 2004	3. Time of Death 4 10:00 P. M
	/Medic Examin		4a. Facility Name (If not institution, s	give street and number	)		4b. City,	Town, or	Location	of Death	riay		county of Dea	
	LAGIIIII	iei	9304 Bremerton				Mon	tgor	nery	Vi11	age	Mor	ntgomen	ry
0	Funeral Director		028-12-6702	Sex 7. A	ge (In yrs. i 78	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Aug. 13	y, Year)	9. Bir Co	thplace (State or Foreign ountry) MA
	be filed within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f ehow event, the Medical Examiner must be notified at	al Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgot  10e. Street and Number  9304 Bremerton Wa	-		y. Town or Lo		Code				10g. Citiz	en of What Co	10d. Inside City Limits 1 □ Yes 2 점 No puntry?
	urs after deet at', or items '	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces d 1 Tyes 2 K If Yes, Give Year or Dates:	? ] No		Was Deced If Yes, spec				ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whi Specify: W	
213-0030	within 72 hours after ene. than "natural", or its the Medical Exemine	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)		5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	ation furing mos	t of work	ing	16b. Kin	d of Business	/Industry
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<u>ya</u>	2 should be and Mental is marked o raumatic eve	2	Robert Penn								Luca			
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Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic as once.		Charles Dym -Hu  20a. Method of Disposition  1 □ Burial 2 ★ Cremation 3		20b. P	9304 Place of Dispo emetery, crea	Breme sition (Nam matory or of	erto: ne of ther place	n Way		Date	20c. Loc	ation - City or	
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68760,	certificate be executed adding physician and use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequ	uence of):								
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	To the To the comp	Ň	29b. Signature and title of certifier	1-11		>			3293				signed (Mon.	th, Day, Year) 04
	5		Frederick Pear	no completed cause of son Smith,				Visc	onsin	Ave	nue, Ch	evy (	Chase.N	4d. 20815
	Sta Regist	ate rar	31. Date filed (Mogth Day, Year)	2004	itrar's Signa		Sport							

			For State Registrar	State of N	Maryland / Do	epartment of I Dertificate of	Health and <i>Death</i>	Mental Hyg	jiene 2 (	04	16826
	Physici		Decedent's Name (First, Middle, Last)     HARRY	JAMES	Do	ONOHUE		2. Date of Dear Month	th Day	Year O4	3. Time of Death  5: 30 A M
	/Medio Examin		4a. Facility Name (If not institution, give s		ar)	4b. City, Town, o	or Location of Dea	ath	4c. County	/	
	Funeral Director		104-20-7032	M 2□F	Age (In yrs. last birth 72 Y	Months Davs			, 1931	Coun	place (State or Foreign htry) ENNSYLVANIA
-	Maryland -f show	tor	Usuel Residence of Decedent           10a. State         10b. County           MARYLAND         WORCEST	'ER	10c. City, Town	or Location SHOPVILLE				11	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	th with the 23a or 28a	al Director	10e. Street and Number 11542 BACK CREE		31.	10f. Zip Code 2181	.1	1	0g. Citizen of V		itry?
36	nurs atter death with the Maryla al', or Items 23a or 28a-f shov Evand et must be rediffed at	by Funeral	11. Marital Status  1   Never Married 2   Married  3   Widowed 4   Divorced	12. Was Deceder Armed Force 1 X Yes 2 [ If Yes, Give Year or Dates	s?	13. Was Decedent of I If Yes, specify Cub	an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		e - Americ ck, White, o	
Maryland 21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2		(	Decedent's Usual Occup Give kind of work done life. DO NOT use retire TRUCK DRI	during most of w d)	rorking	16b. Kind of B		
land 2	nd 2 should be filed within lith and Mental Hyglene. 27 Is marked other than " rtraumatic event, I'm Me.	To Be Co	17. Father's Name (First, Middle, Last)  ARTHUR I	•	DONOHUE			ame (First, Middle, I		ne)	
, Mary	d 2 h a 7 ls	2	19a. Informant's Name/Relationship (Ty KEITH E. MACKABEE		74	Mailing Address (Street		ARSONSBURG	G, MARY	LAND	21849
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other 20059.		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐ P  4 ☐ Donation 5 ☐ Other (Specify)		te cemetery	Disposition (Name of crematory or other pla	MARVA 5		20c. Location -		
Bal	permii Depar Impor any ir		21. Signature of Fineral Service Licens  23a Part Foter the disease or complete	Hall	ed the death. Do no	22. Name and Addre	UNERAL I			, DE.	19975 Approximate
	Physician /Medical		23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		1 /	glic co	2/4/202				Interval Between Onset and Death
6	Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dause Unisases or injury that initialed events	Due to (or a	as a consequence of	):					
8-29-1931 4-28-04 18760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or a	as a consequence of	·):					
0.0.0 Comb 45 0. Box 68	death certii e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death tat time of death	3 □Ectopic pregnanc 5 □ Other (specify) _				te of delive	ery Day Year
Harry 1032 ords, P	The law requires that the deate has been signed by the page 2 should be detached	þ	Part II. Other significant conditions col	ntributing to death	h but not resulting in	the underlying cause gr	ven in Part I.				ne cause of death?
Me.	The law requate has been page 2 should	Completed			<u> </u>			24a. Was a autops perform	in 24b. 'sy med?	Were autor prior to con death? 1  Yes	psy findings available mpletion of cause of 2 No
Oonal Ict. of Vital	ding Physicien: The In.  After this certificate he Inneral director, page	To Be	T Tes 25 NO	and the second second second	atient 2 ER/Outp	atient 3 DOA	her: 4 🗆 Nursing	eath (Check only on Home 5 Reside	ence 6 🗆 Oth		1)
Division (	tent leath tor: the	Certification:	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  25 Pending investigation  6 Could not be determined	28a. Date of In (Month, I		ury Wo	]Yes 2 □No	28d. Describe ho	reet and Numb		l Route Number,
٦	To the Hospital or At within 24 hours after of To the Funeral Direct completely tilled in by	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the be ner: On the basis and manner	s of examination and	death occurred at the ti for investigation, in my	ime, date and pla opinion, death oc	ce, and due to the co	ause(s) and ma ate and place,	anner as stand due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		K B	29c. Licen:	se number	3	9d. Date signe	d (Month, L	Day, Year)
3+1	VADR			16.)	9733 F	Type, Print) Hez / Thwe.	, 0-	12 13	erlis	, M	نر
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 6 20		istrar's Signature	& span	les				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10, Day 2004 Year May **Physician** 9:07P. M Patricia Ann Erno /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 26, 1927 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F 76 Washington, D.C Director 579-40-4425 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Prince George's Laurel 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20708 United States 9270-68 Cherry Lane or Iteme 23s death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: þ 3℃ Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rmii. Pages 1 and 2 should be filed within 7 spartment of Health and Mental Hygiene. sportant: if item 27 is marked other than "1 yorlauty or other traumatic event. Its Med. DGs. Elementary/Secondary (0-12) College (1-4or 5+) then Registered Nurse Washington Hosp. Ctr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lunsford Katherine James ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Buttles Avenue Columbus, Ohio 43215 Michael G. Council -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of t-Important: If ite 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 5/13/2004 Cheltenham, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livens Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 once. Iny 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RUPTURE OF THORACIC ANEURYSM /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on one examiner? 1 XYes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide pelli 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27837 MAY 10, 2004 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUENUE TAKOMA PARK MARKAND 20912 LARCA 7901 MAPLE LOUIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature Looker Registrar

	1	For State Registrer	State of M	laryland / [	epartme Certifica			nd Me		giene Reg. No. 2	004	1682
Physiciar /Medica		Decedent's Name (First, Middle, L     Robert Lore     As Facility Name (If not institution, gi	nzo Er	vin	4h Ci	ty Town o	Location of I		Date of Dea Month	Day 07 20 4c. County		3. Time of Death 00:35 am
Examine		Southern Mary  5. Social Security Number 6.	rland Hos		thday) _ If Un	Clin der 1 Year	ton	Hrs. 8	Date of Birt	Pri	nce	George lace (State or Foreign
Director	1-	Usual Residence of Decedent	1 <u>Ş</u> M 2□F	85	Yrs. Month	s Days	Hours	Min.	(Month, Da)	y, rear) 19/18	N.C	
after death with the Marylan or items 23e or 28a-f show the fortilities at the fortilitie	ector	Md P.G.	<del></del>	Uppe	r Mar		)					0d. Inside City Limits  1√□ Yes 2 □ No
death with the ms 23e or 28a minute for colline	a Dir	10e. Street and Number 10408 Wyld D	rive		10f.	Zip Code 207	72			10g. Citizen of US		itry?
)S = 1	by run	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	No		cedent of H pecify Cuba 2 No	ispanic Origir In, Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- an, etc.)	Bla	ce - Americ ck, White, V: Bla	etc.
nd 21215-0036 e filed within 72 hours aff al flygiene. other then "naturel", or vant, the Medical Expiri	Completed	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)		16a.	Decedent's U (Give kind of life. DO NOT Ostal	work done o use retired	during most o I)	of working		16b. Kind of B		
and de file and Hy sed oth	10 86	12th 17. Father's Name (First, Middle, Las Robert Ervir							First, Middle,	Maiden Sumar		
and 2 shout and Me mark m 27 Is mark har traumati		19a. Informant's Name/Relationship Robert L. Erv	- •							arlbor		Code) 20772 wn, State
Baltimore, permit. Pages 1 an Department of Heal mportent: If item 2 any jolury or githan any jolury or githan and the second of		20a. Method of Disposition  1  ☐ Burial 2 ☐ Cremation 3  4  ☐ Donation 5 ☐ Other (Spec	ify)	Cerneter	ltenha	im	5	/12,		Chelt		
Ball permi Depar Impo any ir		21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or conshock, or heart failure. List only	ensee	ed the death. Do r	Snea 5732	d Fu	ss of Facility neral RGIA g. such as ca	Hon Ave	ne & (	Cremat ashing	ion ton,	Service DC 20011
De de lois	lical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or and c.	s a consequence of	50)		.,,,		111100	TION		
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		e of pregnancy 2  Fetal death at time of death	3 □Ectopic 5 □ Other						te of delive	ry Day Year
cords, P	۱	Part II. Other significent conditions DEME	-	but not resulting in	the underlyin	g cause give	en in Part I.			obacco use cont ∕es 2 □ No	ribute to th	e cause of death? ably 4 Unknown
	Completed							_	24a. Was autop perior 1 Yes	rmed?	prior to cor death?	osy findings available inpletion of cause of 2000 No
of Vita	10 12	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital: 1 Inpat	ient 2 ER/Ou	tpatient 3	DOA Oth	-		5 🗌 Resid	<i>ne)</i> Ience 6 ⊟Oth	er (Specify	·)
Vision of Vita Attanding Physician: Geath. setor: After this certificator. by the funeral director.		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati		ury 28b. T ay Year) li	ime of njury M	28c. Injun Worl	/at <br Yes 2 □ No		1. Describe h	ow injury occur	red	
- 5 2 2 0 C	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of Ir building, e	njury - At home, fa etc. <i>(Specify)</i>					City or Tow	m, State)		l Route Number,
the Hospitel nin 24 hours a tha Funaral I npletely filled	edical	29a. Certifier Check only one) Certifying F	Physicien: To the bes aminer: On the basis and manner s	of examination an	, death occurr d/or investigat	ed at the tin on, in my o	ne, date and p pinion, death	place, and occurred	I due to the d at the time, d	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
To the within comp	M	29b. Signature and title of gertifier	M			29c. Licenson	5388	35		29d. Date signe		
		11 4 6 1/ 4	completed cause of	7501 S	Type, Print)	175 1	loas	#	307	5/	TUN Z	MD 2735
State Registra		31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	9 de	aks	1					

			1 - For State Registrar	State of Maryla	nd / Depa	artment o	f Health an of Death	d Mental Hy	giene 2004	16829
	Physici /Media	al	Decedent's Name (First, Middle, La.     Iraj Jafari     4e. Fecility Name (If not institution, giv.)	Moghadam	Far				9, 2004 Yeer	3. Time of Death 5:17 ρ M
	Examir Funeral Director	er	Howard County  5. Social Security Number 6. S	General Hos	spital s. last birthday) Yrs.	Colum If Under 1 Y	ear If Under 24		4c. County of Deat  Howard  th (20) (1) (2) (1) (3) (4) (4) (5) (6) (7) (7) (7) (8) (8) (9) (8) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	thplece (State or Foreign
	the Maryland 28a-f show	rector	Usuel Residence of Decedent  10a. State 10b. County  Md. Howard  10e. Street and Number		ity, Town or Lo 1 umbia		de		10g. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importents if Item 27 is marked other than "naturel" or items 23a or 28a-f show importent. If Item 27 is marked other than "naturel" or items 23a or 28a-f show any injuryer other traumatic event, the Medical Examination in the Indianal Percentilist and page.	by Funeral Director	7577 Weatherwo  11. Marital Status  1 Never Married 2(X Married 3 Widowed 4 Divorced	rn Way, Apt  12. Was Decedent Ever in I Armed Forces?  1 — Yes 2 I No If Yes, Give Year or Dates:	U.S. 13. V			? (Specify Yes or No uerto Rican, etc.)	U.S.A.  14. Race - Ame Black, White	nican Indian,
21215-0036	ad within 72 hour giene. er than "naturel"	To Be Completed b	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation		lent's Usual Od kind of work do OO NOT use re Offi	ccupation one during most of tired)	working	16b. Kind of Business/	
Maryland	should be filed and Mental Hygi marked other imatic event, I	To Be (	19a. Informant's Name/Relationship (	i Moghadam Type, Print)	Fard	g Address (Str	Maso		Maiden Sumame) anlari er, City or Town, State, 2	Zip Code)
	jes 1 and 2 s of Health ar if item 27 is or other trau		Pedram Fard /  20a. Method of Disposition  1 🖾 Burial 2 🗆 Cremation 3 🗆	S O N 20b.	1152 Place of Dispo cemetery, cren	Kett sition (Name on natory or other	le Pond	Ln., Gr	eat Falls 20c. Location - City or	, Va22066 Town, Stete
Baltimore,	permit. Peg Department Importent: I eny injurye pnce.		*4 Donation 5 Other (Specification of Signature of Funeral Service Licer		22	Name and A	dress of Facility	Univers	Falls Chu al Mortua Wash. D.	iry
760,	bath certificate be executed  Ex  attending physicien and for use as the burial-transit	licai Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Mxocar	dial quence of): clers t	Dn Fa	vetio.	_	disease	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph page 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregna Other (specify			23d. Date of deli Month	ivery Day Year
Records, P.	w requires that been signed b should be deta	ted by Pt	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	iderlying cause	given in Part I.	11	obacco use contribute to Yes 2 □ No 3 □ Pro	
al Reco		Completed by							rmed? prior to death?	topsy findings available completion of cause of
Division of Vital	this ald	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 XNo  27. Manner of Death  1 XNatural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. [	Othor		ne) dence 6 Other (Spec	elfy)
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	i Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Spec	ify)			City or Tox		
	To the Hos within 24 hd To the Fun completely it	Medicai		ysician: To the best of my kn niner: On the basis of examin and manner stated.	ation and/or inv	estigation, in n	e time, date and pi ny opinion, death o ense number	ccurred at the time,	cause(s) and manner as date and place, and due	to the cause(s)
	10		30. Name and address of person who		1-0. om 23a) (Type, 1	Print) Cedar	Lune	Columbi	5/10/04	1044
3	Sta Registi		31. Date filed (Month, Day, Year)  MAY 13 20	32. Registrar's Sign	nature &	Span	h	****	,	J

			For State Registrar				lealth and Me	ental Hygie	ene 2004	16830
	Physicia	20	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
4	/Medic	al	Sarah Cristin Flo			4h City Town o	r Location of Death	5-1	2 - 04 4c. County of Death	01234
	Examin	er	4a. Facility Name (If not institution, give	1 /		Silvar	Socing		Montgo	
	Funeral		5. Social Security Number 6. Se	7. Age	e (In yrs. last birthda	y) If Under 1 Year Months Days		8. Date of Birth (Month, Pay,	(ear) 9. Birth	notace (State or Foreign
	Director		None 1	☐M 2 <b>[</b> ]F	Yrs.	Mortus Days	Hours Min.	5-11-0	4 Ma	ryland
	pur *	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. tnside City Limits
	Maryla f sho	ō	Maryland Montgom	ery	Silver S	Spring				1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	untry?
	th with		9128 September La	ne		20901		U	SA	
	r deal	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		<ol> <li>Was Decedent of H tf Yes, specify Cub</li> </ol>	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by Fi	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N tf Yes, Give Year or Dates:	No	1⊠ Yes 2□ No	Specify: Argent	tinian	Specify: W	hite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  dother than "natural", or flems 23a or 28a-f show od other than "natural", or flems 23a or 28a-f show event. Itse Medical Examinar most be notified at	ted t	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occup	oation	1	6b. Kind of Business/	
215	hin 73	Completed	(Specify only highest gra-	de completed) College (1-4or 5	life	. DO NOT use retire	during most of working d)	ig		
21	e filed with al Hygiene. other than	Cou	0		Neve	r Worked	18. Mother's Name	(First Middle M	nidos Sumamo)	
and	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, Last) George H. Flores					r S. Gir		
7	should ind Men ind marke umatic	2	19a. Informant's Name/Relationship (7	"ype, Print)	19b. Ma	iling Address (Street			City or Town, State, Z	ïp Code)
			Jennifer S. Giron		9128	Septembe	r Ln. Silv	ver Spri	ng, MD 209	01
ore,	of Health of Health Item 27 I		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐		20b. Place of Dis	position (Name of rematory or other pla Litan	D		Oc. Location - City or 1	
Ë	artment ortant: If		'4 □Donation 5 □ Other (Specify			Cremato	ry + 5/14	/2004 A	lexandria,	VA
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licen	See O.		22. Name and Addre Francis J.		Funeral	Home, Inc.	
	707 e a		23a. Part1. Enter the disease, or common shock, or heart failure. List only	plications that caused	the death. Do not e	500 Univer	sity Blvd	r respiratory arres	ver Spring	MD 20901 Approximate
F			shock, or heart failure. List only Immediate Cause (Finat			L		. ,		Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. <u>Cordia</u>	a consequence of):	T		<u> </u>		2hrs 13min
	Examiner		Sequentially list conditions	b						
	p H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):					
	be executed iician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
760,	te be executed ysician and ne burial-transit	cal E		4	4					
687	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the			, d						
Вох	leath certificate attending phys I for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □Ectopic pregnanc	ev		23d. Date of deli	
-	deati he atte ed for	sicla	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant a 9☐Unknown		5 Other (specify)	,		Month	Day Year
P.0	that the de led by the a detached f	Phy	9 Unknown Part II. Other significent conditions of	ontributing to death t	out not resulting in the	a underlying cause or	ven in Part I	23e. Did toba	acco use contribute to	the cause of death?
ds,	signed I	d by	Partition and and and and and and and and and an	onthis damag to social a	, at the total and	and any my address gr		1 □ Yes	2 <b>P</b> No 3 □ Pro	obably 4 Unknown
Records,	w requir been si should	Completed						24a. Was an	24b. Were au	topsy findings available
Re	The lav	ошо						autopsy perform 1 Yes 2	ed? death?	completion of cause of 2 ☐ No
Vita	ician: Th certificate rector, pag	O)	25. Was case referred to medical				26. Place of Death			20110
75	Physici this ce al direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impati		Hent 3 DOA			nce 6 Other (Spec	oify)
n of	ding P h. After t funera	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injur	y Wo	iryat ork? ]Yes 2. □No	28d. Describe hov	w injury occurred	
División	l or Attending Physician: after death. Dire tor: After this certification in by the funeral director.	icat	2 Accident investigation 3 Suicide 6 Could not b	e con Plana of In	iury - At home, farm,			28f. Location (Str	eet and Number or Ru	ıral Route Number,
Div	after after Dire	Certification:	4 Homicide determined	building, e	tc. (Specify)	,		City or Town,	State)	
	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C			of examination and/or				use(s) and manner as te and place, and due	
	To the Within 2 To the comple	Med	29b. Signature and title of certifier				se number		d. Date signed (Month	n, Day, Year)
*			1	NO		AH2	328/95-TG	-56	5/10	2/04
			30. Name and address of person who	completed cause of		pe, Print)	228/95-70 Rd Sil			
			T. Lancaster, N 31. Date filed (Month, Day, Year)	1D 150	O Fores	of Glen	Kd Sil	ver Sp	ring	
	St Regist	ate trar		104 Jens	we B	pock	2			

			State of Maryland / Department State of Maryland / Department Certification	nt of Health and M <i>te of Death</i>	1ental Hygier 1.egg. t	60114	1683
	Physi		1. Decedent's Name (First, Middle, Last) Sylvia GOOZH		2 Date of Death	Dav Year	3. Time of Death 6:10 A. M
	/Med Exam		4a. Facility Name (If not institution, give street and number)  Suburban Hospital  4b. City	r, Town, or Location of Death Bethesda	4	tc. County of Death Montgomer	у
	Funera Directo		5. Social Security Number 6. Sex 1 Months 1 Months 1 Age (In yrs. last birthday) 1 Under Months 2 M F 89 Yrs.	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea Dec. 29, 1	9. Birth Cou 914 Mary	place (State or Foreign ntry) Land
	and **		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryl	tor	MD Montgomery Chevy Cha	se			1 ⊈Yes 2 ☐ No
	h with the 23a or 28a st be not	Funeral Director	10e. Street and Number 8100 Conn. Ave. #514	ip Code 20815	10g. (	Citizen of What Cou	-
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, in the Model Executive must be notified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 W Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Spe 1 Yes or Dates:  13. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto  2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
	Maryland 21215-0036 nd 2 should be filed within 72 hours aft inth and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Marical Extra	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Ust (Give kind of wife. DO NOT: Homem	ual Occupation ork done during most of worki use retired) 1aker	ing 16b.	Kind of Business/In	·
	land 2 Id be filed ental Hygicked other ic event, III	To Be Co	17. Father's Name (First, Middle, Last)  Morris Weinstein		e (First, Middle, Maide e Lippman	en Sumame)	
	Mary 12 shou h and M 7 is mar			ss (Street and Number or Rura wick St., N.W	al Route Number, City		,
	ore, less 1 and of Health litem 2.	П	20a. Method of Disposition 20b. Place of Disposition (Na	ame of		Location - City or To	
	Baltimore, permit. Pages 1 ar popartment of Heal mportant: If item in injury or other		'4 Donation 5 Other (Specify)  B'nai Israel	Cemetery May			
	Depa limpo	PAIN A		arroll St., N			
7	Physician /Medica	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
10.AM	Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
0190	. Box 68760, death certificate be executed a attending physician and of for use as the burial-transit	edicai Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):  d				
40/21	Box (death certified at the death certified a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  Obb 9  Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown 5  Other (s			23d. Date of delive Month	ery Day Year
163	ords, P.O requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		use contribute to the	he cause of death?
410	Vital Records, ician: The law requires t certificate has been signs ector, page 2 should be	Completed			24a. Was an autopsy performed?	prior to co death?	ppsy findings available impletion of cause of
-	Vita ician: certific ector,	Be	25. Was case referred to medical examiner?	0.4	(Check only one)		
S	Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 193 2 PAO 1 Parinpatient 2 EH/Outpatient 3 D		me 5 Residence 28d. Describe how inj		(V
420	Division  al or Attending safter death. if Director: After id in by the fune	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office	28f. Location (Street a City or Town, Sta	and Number or Rura te)	il Route Number,
200	ne Hospita 124 hours ne Funera eletely fille	edical (	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred and manner: On the basis of examination and/or investigation and manner stated.	1 at the time, date and place, and in my opinion, death occurr	and due to the cause( ed at the time, date a	s) and manner as sind place, and due to	lated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29	DOO 571		Pate signed (Month,	Day, Year) D C-1
	>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert H. Blee, MD 5530 Wisconsin Ave.,	#1400 Chevy	Chase, MD	20815	
	Regis	tate strar	31. Date filed (Month, Day, Year) 32. Begistrar's Signature	als			

			Registrar	State of Marylan	d / Depa	artment rtificate	of H	ealth a		ntal Hygi	g. No.	) 4	16832
	Physici /Medi	al	Decedent's Name (First, Middle, Last)     Albert T. Greatore:     4a. Facility Name (If not institution, give st.)			4h City T	Own or	Location of	Ma	Date of Death Month By 4,		/ear	3. Time of Death
	Examir Funeral Director	ier	Montgomery General 5. Social Security Number 6. Sex		last birthday) Yrs.	01ne	ey	If Under 2	24 Hrs. 8.	Date of Birth (Month, Day, ay 10,	Montgo	mery 9. Birthpli Count	ace (State or Foreign
, Maryland 21215-0036	es 1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23e or 28e-f show r other traumatic event. It a Modicul Exertine must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomer  10e. Street and Number  14306 Yosemite Cou	y Roc  Tt  2. Was Decedent Ever in U. Armed Forces? 1 (XYes, Give Year or Dates: WW I. completed)  College (1-4or 5+) 5+	I 16a. Deced (Give life. Train	e 10f. Zip o 20 20 20 20 20 20 20 20 20 20 20 20 20	D853 ent of His fy Cubar No Occupa k done die eretired) ffic	Specify: tion uring most er 18. Mother Mary	of working  's Name (Fi  Fulto	Yes or No- an, etc.)  1  (crst, Middle, M	ng. Citizen of Who nited S	tate America White, e Thite ness/ind State ent	Dd. Inside City Limits  1  Yes 2 No  ry?  San Indian, etc.  ustry  ES  Code)
Baltimore,	permit. Pages 1 a Department of Hes Importent: if itam any injury or othe		20a. Method of Disposition  1 Burial 2 X remation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licen	moval from State Mor	lace of Dispo emetery, crer 1tgomen remato Ro	sition (Name matory or oth ry rium, Name and ckvil	e of her place Inc. LAddress Ie.	of Facility	lay 7, 200 Rober	2 4 F	oc.Location - C Bethesda umphrey	ty or Tov	vn, State
68760,	death certificate be executed  e attending physician and for use as the buriat-transit	cal Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage or all y that initiated events resulting in death) Last	Emphysema  Due to (or as a consequence to (or a))).	uence of):	er the mode	of dying	, such as c	eardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
.O. Box	that the death certificate bed by the attending physic detached for use as the b	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pre					23d. Date of Month		y Day Year
ords, P	equires that en signed outd be de	by	Part II. Dther significant conditions control  CONGESTIVE HEART F		ulting in the ui	nderlying ca	use giver	n in Part I.					e cause of death?
al Record	The law ate has b page 2 sl	Completed	CARDIOMYOPATHY						_	24a. Was an autopsy performe	ed? prid	r to com	sy findings available pletion of cause of
ion of Vital	Attending Physician: Thir death. actor: After this certificate by the funeral director, pag	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 X No Ho  27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	spital: 1 X Inpatient 2   28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		c. Injury Work	4 □ Nur	sing Home 28d.		ce 6 Other		
Division	r te c	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory,	office			Location (Stre City or Town,	eet and Number State)	or Rurai	Route Number,
	To the Hospital c	Aedical	(Check only 2 Medical Examine one)	rian: To the best of my known on the basis of examinat and manner stated.	wiedge, death tion and/or inv	estigation, i	in my opi	nion, death	place, and occurred a	t the time, dat	e and place, and	due to t	the cause(s)
l	14 01	æ	29b. Signature and title of certifier	))	1. P.	D0	License				ay 6, 20		ay, Year)
_			James Morton, M.D.	pleted cause of death (Item			r.,	01ney	, Mar	yland	20832		
	Sta Regist		31. Date filed (Month, Day, Year)  MAY 10 2004	32. Registrar's Signal	ture	Spo	eks	/					

			1 - For Stete Registra/MEND#23a(a&b)	State of Ma cerMD5/10/04							,	giene Reg. No. 2	001	160	000
ı	Physici /Medi		1. Decedent's Name (First, Middle, Las Agnes R. Gross	,							2. Date of Dea Month May	Day	Year 2004	3. Time of 9:00	рм Рм
}	Examir		4a. Facility Name (If not institution, give	street and number)		•	4b. City,	Town, or	Location	of Death			unty of Death		
			Montgomery Gener  5. Social Security Number 6. Se			. last birthday)	01r	ney r 1 Year	If Under	24 Hrs	8. Date of Birt		ntgome		
	Funeral Director		577-05-5350	☐ M 224F	86	Yrs.	Months		Hours	Min.	(Month, Day Aug. 1	y, Year)	. Cou	pplace (State or intry) nington	_
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside Cit	ly Limits
	e Man	ctor	Maryland Montgom	ery	Si	ilver S	prin	g						1 🗆 Yes	2 🔀 No
	vith th	Director	10e. Street and Number				10f. Zip					10g. Citizer	of What Cou	intry?	
	ns 23	erai	2921 North Leisu	ire World 12. Was Decedent				20906		igin? /So	ecify Yes or No-	14	USA Race - Amer	iona Indian	
Maryland 21215-0036	a within 72 hours after death with the Maryland Jiene. r then "naturel", or items 23a or 28e-1 show the Medical Examinat must be notified at	by Funeral	1 □ Never Married 2 □ Married 3 ② Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:			f Yes, spe	cify Cuba	Specify:	n, Puerto	Rican, etc.)		Black, White ecity: Wh1	, etc.	
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Deced	kind of we	ork done o	turing mos	t of worki	na	16b. Kind	of Business/Ir	ndustry	
121	within 72 ene. then "nat	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Cle	ם זטא טכ	se retired,	)		9	Corre	ernmen	<b>-</b>	
d 2	9 × 5 + 1	Be Co	17. Father's Name (First, Middle, Last)			010			18. Mothe	er's Name	(First, Middle,				
/lan	2 should be fil and Mental H is marked ott	To B	Benjamin Messick						Bla:	nche	Talbe:	rt			
Mar	12 shoutd by and Ment 7 is marked reumatic 6		19a. Informant's Name/Relationship (7								l Route Numbe				
	1 and Healtl tem 2		Irene Sanchez/ F:	riend	20b. F	Place of Dispo	sition (Na	me of			, Gaith		on - City or T		
ē	Pages ent of		1 Burial 2 ACremation 3 1			cemetery, cren cropoli				Ma	y 6,		ndria,		in i o
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any injury gcother treumatic e		21. Signature of Funeral Service Licens								Funeral			Virgi	nia
<u> </u>	8959		1 William	7 13/		50	00 Un	ivers	sity	B1vd	. W., S	ilver	Spring	g, MD 2	0901
	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused one cause on each lin ASPITA a.  Pneumoni  Due to (or as a	tio	n Pn€	er the mod		g, such as	cardiac o	r respiratory arr	rest,		Approximate Interval Betw Onset and Di 1 Week	veen leath
8760,	cate be executed physician and the burial-transit and	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Recurrer  Due to (or as a  c.  Due to (or as a  d.	t As	sp <b>irati</b> quence of):	on-							1 Mont	li-
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Feta	ıl déath 3 □	Ectopic pr Other (sp					23d.	Date of delive Month		ear
ds, P	es bed	by	Part II. Other significant conditions co Arteriosclerotic					ause give	n in Part I.			_		he cause of dec	
Records,	> 10 00	lete	1110011001101011	ocicpiova	ocur.	ar Disc	ase				24a. Was a				
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	ys Si ib	ToB	examiner?	Hospital: 1 🗷 Inpatier	nt 2 🗆	ER/Outpatient	3 DO	Othe			(Check only on ne 5 ☐ Reside		Other (Specifi	v)	
	ding h. After fune	ation:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	M 2	8c. Injury Work' 1   Y		2	8d. Describe ho				
Division	声름	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specif)	ome, farm, stre y)	et, factory	, office		2	8f. Location (St City or Town	reet and Nu n, State)	mber or Rura	i Route Numbe	9r,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier 1  Certifying Phy (Check only one)	sician: To the best o ner: On the basis of and manner stat	examına	wledge, death tion and/or inv	occurred estigation,	at the time in my opi	e, date and inion, deat	d place, a h occurre	nd due to the ca d at the time, da	ause(s) and ate and plac	manner as st	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		2		290	. License	number		2	9d. Date sig	ned (Month,	Day, Year)	
	20	-	> Jman					D245	43			May	6, 2	2004	
			30. Name and address of person who co				,	Jor 1 -	p1	a r	Silver S	Consider	MD C	20006	
	Sta		31. Date filed (Month, Day, Year)	32. Registra				ush		ن و د ند	TIVEL ;	shring	, MID Z	0906	
	Registra	ar	MAY 1 0 200	14 Denes		10	apo	RAN							

			State of Maryla				_	_	•
		1 = For State Registrar	J		rtificate of L			leg. No. 200	4 1683
		1. Decedent's Name (First, Middle, Last	9				2. Date of Dea Month		3. Time of Death
Physic /Med		Donald Hamburg	er				5-6-200		7:15 P. M
Exam		4a. Fecility Name (If not institution, give			4b. City, Town, or			4c. County of De	
	10.00	Brooke Grove Rehal		s. last birthday)	Sandy Sp	ring If Under 24 Hrs.	9 Date of Birth	Montgom	
Funera Director			M 2□F 80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 3-4-24	Year) Wa	irthplace (State or Foreign Country) ish., D. C.
yland	1.	10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
e Ma	cto	MD Montgome	ry Si	llver S	pring				1 □ Yes 2√2 No
vith th	Dire	10e. Street and Number			10f. Zip Code			Og. Citizen of What (	Country?
eath v	erai	4 Aquarius Ct.	12. Was Decedent Ever in	IIS 13	2090			U.S.A.	nerican Indian,
fter d	Fun	1 Never Married 2 Married	Amed Forces? 1 ⊠Yes 2 □ No		Was Decedent of His If Yes, specify Cubar		Rican, etc.)	Black, Wh	nite, etc.
Durs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: WW-	·II	1 ☐ Yes 2 🔀 No	Specify:		Specify: W	Mite
Minin 72 hours after death with the Maryland one. then "natural", or Items 23e or 28e-f show the Mayles Exertines must be notified at	etec	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done d	uring most of worki	ing	16b. Kind of Busines	s/Industry
within she	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			D	D . C
Daltimore, Maryland ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or any injury or other traumatic avant, tra Madical Everi proce.	ပိ	17. Father's Name (First, Middle, Last)		Resea	ırch Analy	18. Mother's Name		Dept. of	Derense
id be ental ked c	0 8	Sam Hamburger				Bessie	Emmart	,	
shou and M mar		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	ng Address (Street a	nd Number or Rura	al Route Number	, City or Town, State	Zip Code)
and 2 salth in 27 i		Marguerite Hamburg	er - Wife	4 Aq	uarius Ct	. Silver	Spring,	MD 20906	
Defilitioner, Maryjariu ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Nems 23a or 28a-1 show any injury or pothar traumatic avant, the Modical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		Place of Dispo cemetery, crei	osition (Name of matory or other place	,	Date	20c. Location - City of	or Town, State
tant:		* 4 □ Donation 5 □ Other (Specify)	)   L		Park Crem.	5-9-	-04	Baltimore	, MD
Deparmi Depar Mpor Mpor Dnce.		21. Signature of Funeral Service Licens	000011136	. 22				ldi F. H.	MD 2000/
		23a. Part 1. Enter the disease, or comp	lications that caused the de	ath. Do not ent				r Spring,	Approximate
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Aci	He to	byler	necvosi	5		Interval Between Onset and Death
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rou, te be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events	c.						
te be exe ysician a		resulting in death) Last	Due to (or as a conse	equence of):					
cate b	dical		d			<del></del>			
certification ding physe as the	/Me	IF FEMALE:	23c. If yes, outcome of pregi	nancv	- Thehe			and Date of d	
of T.C. BOX 00100, that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of di Month	Day Year
hat the d d by the letached	hys	9 Unknown	9□ Unknown						
OI VILGI RECOIDS, F.O. BOX 06 Physician: The law requires that the death certifica r this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	ed by P	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause give	n in Part I.	23e. Did tob	1 -	to the cause of death?  Probably 4 Unknown
has be	Completed						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
The The page	Com						perform	ned? death?	s 2 No
cian: entific actor,	Be	25. Was case referred to medical examiner?	lah-l			26. Place of Death			
Physical this call direction	2	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 [ 28a. Date of Injury	☐ ER/Outpatien 28b. Time of		Nursing Hor		nce 6 Other (Sp	ecity)
After funer	tion	Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work'	at ? es 2 □No	zad. Describe no	w injury occurred	
lor Attending Physician: The law requires ta after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be continued.	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str city)			28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
Hospita 4 hours Funeral ely filled	Medical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exemi	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death	n occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	and due to the ca	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of gertifier,	/		29c. License	number	25	9d. Date signed (Mon	ith, Dey, Year)
7		· Clul Attest	Phys	steres	Do	,55694		May 6	1 2004
1		A. A.	ompleted cause of death (Ite	эт 23а) (Туре,	Print)	ili. D	/ Oi.	MA D	0627
· ·			HUIZ 4000	Olre,	Y - LC Y +0151	VIIIE KU	019	cy, 1110 C	U8>2
St Regist	tate trar	31. Date filed (Month, Day, Year)  MAY 1 0 20	32. Registrar's Sign	lature 4	Sporth	1		ey, HI) 2	

1	arrers	011	1 - For State Registrar	State of	Marylar		artmen rtificat				lental Hyg	P 2	004	16835
	Physici /Medi		Decedent's Name (First, Middle,     JERRY E		LSON						2. Date of Deal Month 08		Year	3. Time of Death 0956A. M
	Examir		4a. Facility Name (If not institution, 18211 Lost Knif		ber)				Location of			4c. County Monto		У
	Funeral Director		257-66-7852	5. Sex 7 1 ⊈M 2 ☐ F	. Age (In yrs. 60	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, OCt. 2,	1943	Cour	place (State or Foreign orgia
	th the Maryland or 28a-f show s notified at	Olrector	10e. Street and Number	tgomery		ty, Town or Lo	tgom	Code		Lage		0g. Citizen of		10d. Inside City Limits 1  Yes 2 □ No ntry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	18 2 1 1 Lost 1 1 Marital Status  1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Deced Armed Forc	ent Ever in U es? No	1				gin? (Spe I, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	S.A. ce - Americ ck, White, W: Wh:	etc.
121215-0036	42 should be filed within 72 ho h and Mental Hygiene. 7 is marked other than "natur traumatic evant, tra Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	grade completed) College (1-4	for 5+)		dent's Usua kind of wor DO NOT us ngine	rk done d se retired)	uring most		ng (First, Middle, M	Unive	ge Wa	ashington
Maryland	nould be fi d Mental H narked ot natic ever	To Be	George Har	relson		401 14 17		(2)	M	iary	Benso	n		
Baltimore, Mai	permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun		19a. Informant's Name/Relationshi Delinda Harre  20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spi 21 Signalure of Funeral Pervice Li	elson (Da	20b. F	er) ! Place of Disponentery, cremetery, cremetery	5413 sition (Nam natory or o inera	Sha ne of ther place al S nd Address	ded rv 5	Vil 5/13 y SN	/04	Rale 20c. Location Alexar FUNERA	eigh City or To ndria AL HO	NC 2761 own, State a, VA OME, P.A.
	Crate be executed  Medical Medical and the buriat-fransit street buriation and the b	edical Examiner	23a. Part1. Enter ne disease, or c shock, or heart failure. List of Immediate Cauv (Final disease or condition resulting in death)  Sequentially list conditions, п алу, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or	r as a consequence as a	juence of):	er the mod					est,		Approximate Interval Between Onset and Death
.O. Box 68	t the death certiff by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Feta nt at time of d	ıldeath 3 □	Ectopic pro Other (sp.						te of delive nth	ery Day Year
ords, P.	v requires tha been signed I should be det	by	Part II. Other significant condition	s contributing to dea	th but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	A.a		ne cause of death? ably 4 □Unknown
		Completed						·			24a. Was ar autops perform 1 Ves 2	/	prior to con death?	psy findings available inpletion of cause of
	or Attanding Physician: I ifter death. Diractor: After this certifical in by the funeral director, p.	Certification; To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death  1 Vatural 5 Pending investiga 2 Accident investiga 3 Suicide 6 Could no	28a. Date of (Month,	Injury Day Year)	ER/Outpatien 28b. Time of Injury	M 2	8c. Injury Work 1  Y	r: 4 □ Nui	rsing Hor	(Check only one ne 5 1 eside 28d. Describe ho	nce 6 Oth	ed	
Div	Hospital or Att 24 hours after d Funeral Diract tely filled in by it		4 Homicide determin	Pnysician: To the b	, etc. (Specif	y) owledge, death	occurred :	at the time	e, date and	d place, a	City or Town	, State) use(s) and ma	inner as st	ated.
<b>)</b>	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	29b. Signature and title of certifier	Lakew	is of examina	ition and/or inv	estigation,	in my op.	nion, deat	h occurre	ed at the time, da	ete and place,  Od. Date signe  May 09	and due to	the cause(s)  Day, Year)
	Sta			ho completed cause		aturo	Print) 1		enn S	tree	t, Balt:	imore,	Mary.	land 21201

			1 - For State Registrar	State of Maryland	d / Depa	artment of H	ealth and N	lental Hygie	ene 2004	16836	5
	Physici	an	1. Decedent's Name (First, Middle, L					2. Date of Death Month	Day Yeer 2004	3. Time of Death	
	/Medic	al	Jesse Graham  4a. Facility Name (If not institution, g	Holland		4h City Town or	Location of Death	May 6,	4c. County of Death	3:15 a <sup>M</sup>	_
	Examin	er"	Kensington Park			Kensing			Montgomery	7	
×	Funeral			Sex 7. Age (In yrs. la	st birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	O. Distri	lace (State or Foreign	1
Ļ	Director		577-09-3463 Usuel Residence of Decedent	1⊠M 2□F 99	9 Yrs.	Wortes	110013	May 3, 1	905	VA	_
	yland how		10a. State 10b. County		Town or Lo				1	Od. Inside City Limits	
	Ba-fs	ctor	MD Montgo	mery S:	ilver	Spring				1 ☐ Yes 2 🛣 No	
	ba filed within 72 hours after death with the Maryland Ital Hygiene. id other then "naturel", or lteme 23a or 28a-f show event, Ira Medical Eracinst must be notified at	Director	10e. Street and Number 3909 Rickover R	d		10f. Zip Code 2090	<b>1</b> 2	10g	g. Citizen of What Cour USA	ntry?	
	ne 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Americ	an Indian,	-
٥	or Iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No				Rican, etc.)	Black, White,	etc.	
9500-61212	hours after turel', or Ite	d by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates: WWII		1 ☐ Yes 2 ☑ No	Specify:		Specify: Whi		
7	"natu	Completed	15. Decedent's (Specify only highest of	Education trade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work	ring 16	6b. Kind of Business/In	dustry	
17	a filed within 72 al Hygiene. other then "na vent, Ine Medic	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		nander	,		U.S. Navy		
D	illed Hygi other	Be C	17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle, Ma			
Maryland	uld be Menta Irked Itic ev	To B	Francis Randol	ph Holland			Elizab	eth Lee V	Mhitley		
al	permit. Pagas 1 and 2 should ba f Department of Health and Mental I Important: If item 27 Is marked of any injury or other traumatic eve ang injury or other traumatic eve		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rur	al Route Number, (	City or Town, State, Zip	Code)	
a) Z	of Health a item 27 ls		Jesse G. Holland 20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of	1		n. 110 209 c. Location - City or To		
9	Agas Ogo		17 Burial 2 ☐ Cremation 3	□Removal from State   Arf	Ington	natory or other place. National	f July	14	lington, V		
Baitimore,	artme ortan injury		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Light		Ceme	etery 2. Name and Addres	20		Collins Fun		-
n	pen dung any		Jany &	i Jale					er Spring,		
31	Pnysician		23a. Part 1. Suter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	iy one cause on each line.	ndia	4	g, such as cardiac Garc 40,		t,	Approximate Interval Between Onset and Death	
h	/Medical Examiner		resulting in death)	Due to (or as a consequence of the second of	ence of):	10515				fears	
,160,	eath certificate ba executed attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence)  d.	enne ut):			· · · · · · · · · · · · · · · · · · ·			
O. Box 68	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal- 4 ☐ Pregnant at time of de	death 3	□Ectopic pregnancy □ Other (specify)	1		23d. Date of delive Month	ery Day Year	
JS, P.	requires that the vaen signed by th hould be detache	by	Part II. Other significant conditions	contributing to death but not resu	lting in the u	nderlying cause give	en in Part I.		cco use contribute to the	ne cause of death?	
Records,	w requires to baen signers should be	Completed						24a. Was an		psv findings available	
ž	rs 97 OI	ошо						autopsy performs	prior to co. death?	mpletion of cause of	1
Vital	(0	Φ	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 22 th (Check only one)	No 1 ☐ Yes	Z L NO	$\dashv$
Ö	ng Phy fter this neral d	ion; To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigat	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	Work	4 <u>X</u> inursing Ho ∕ at	ome 5 Residence 28d. Describe how	ce 6 □Other (Specifinjury occurred	A) -m.	
Division	al or Attending s after death. Il Diractor: After d in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be an Blood of Injury At hou	me, farm, sti			28f. Location (Stre City or Town,	et and Number or Rura State)	il Route Number,	
	To the Hospital or At within 24 hours after or To the Funerel Dirac completely filled in by	edical C	29a. Certifier Certifying (Check only one)	Physician: To the best of my knov aminer: On the basis of examinati and manner stated.	vledge, deat on and/or in	h occurred at the tim vestigation, in my of	ne, date and place, pinion, death occur	and due to the cau rod at the time, date	se(s) and manner as s a and place, and due to	tated. the cause(s)	
	To the within To the	Me	29b. Signature and title of certifier	11/1		29c. License			. Date signed (Month,	Day, Year)	7
	10+1		> Kennell	( J'y MD		VA DI	0/050	0047	5/11/0	24	
			30. Name and address of person wh				_		,		
			Kenneth G. Pug  31. Date filed (Month, Day, Year)	h 8901 Wisconsir 32. Pegistrar's Signat	-			20889			-
	Sta Regist		MAY 13 2		19	Sparks			<i>y</i> -		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CORRELL Month **Physician** FRANCES HUNTER 1ŏ, May 2004 10:10P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Laurel Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 7, 1911 Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 577-12-9682 93 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County Show 10d. Inside City Limits r then "natural", or items 23a or 28a-f shov The Modical Extandiner must be notified at Maryland Prince George's Beltsville 1 ☐ Yes 21 No Direct 10e. Street and Number 4416 Samar Street 10f. Zip Code 10g. Citizen of What Country? 20705 United States death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: White Ď 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Prince George's Co. I Hygiene. Elementary/Secondary (0-12) Board of Education Secretary permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: if item 27 is marked other th
any injury or other treumatic event, III
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John **Gorrell** Florence Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Shearin -Daughter 11909 Lanner Place Laurel, Maryland 20708 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 5/14/2004 Brentwood, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. ld 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Chronic Obstructive Lung Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or orderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \( \text{Yes} \) 2 \( \text{XNo} \) 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the all detached to 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1X Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2**X** No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Mursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending s efter death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel o within 24 hours eff To the Funerel Di TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24997 May 11, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luis A. Casas, M.D. 8317 Cherry Lane Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State sacks! 2004 Registrar 12

ORIGINAL

		1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F			giene Reg. No. 20	04	168	339
Physic	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month May 5,	Day	Year	3. Time of 2:40	Death P M
/Medi Examir		Julia Anna 4a. Facility Name (If not institution, give	Hughes street and number)		4b. City, Town, o	Location of Death		4c. County	of Death	2.40	F
LXamii	101	Lakeside Assisted	lLiving		Salisbu			Wicon	nico		
Funeral Director		5. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	□M 2Dr	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da October	y, Year) 2, 1922	9. Birthpl Count India	ace (State of Try) ana	r Foreign
yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10	d. Inside Cit	ty Limits
he Mar Be-f sl	ctor	Maryland Wicomic	0	Salisbur						1 □XYes	2 □ No
with the	Funeral Directo	10e. Street and Number	la Dead aga	10.0	10f. Zip Code 21804			10g. Citizen of W	hat Count	try?	
Jeath	eral	1109 South Schuma	12. Was Decedent Ex	10–C ver in U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No		- America		
urs after or ter	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	WWII Navy	If Yes, specify Cuba 1☐ Yes 2██ No	in, Mexican, Puerto Specify:	o Rican, etc.)	Specify:	k, White, e	ite	
DESILIMOTE, INIGITYIBING Z   Z   DS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event, the Marylett Examinat I was be inclifted at and:	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bu	siness/Ind	ustry	
A L.	Con	12	1	Hous	ewife	40. Mathada Nasa	- Cina Middle	Homema			
Maryland  10 2 should be file  11 lith and Mental Hy  27 is marked oth  17 reumatic evant	To Be	17. Father's Name (First, Middle, Last)  Gilbert Lee	McKain			Anna	Martha		osgia		
Mar d 2 sh d 2 sh th and th and traum traum		19a. Informant's Name/Relationship (7) Sarah Elizabeth (			ng Address <i>(Street</i> 19 Oak St			-			
<b>Baltimore</b> , permit. Pages 1 an Department of Heal Important: If item 2 any injury or other and		20a. Method of Disposition  1X Burial 2 Cremation 3		20b. Place of Dispo			Date	20c. Location - (		vn, State	
ITIM iit. Pa artmen ortant: injury		<ul> <li>4 ☐ Donation 5 ☐ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>		Maryland Ve	eterans Cem	etery May	10,2004	B∈ulah	, Mai	cyland	1
Deper Per Per Per Per Per Per Per Per Per P		- OM 16	omoon	S. CFSP 5	2. Name and Addre olloway E Ol Snow E	uneral H Will Road	ome Prot , Salish	essional	l Ass cvlan	ociat: d 218	ion 804
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/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
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of ou, cate be executed bhysician and the burial-transit	lical Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):							
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luires that in signed by lid be deta	ğ	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		obacco use contri 'es 2 No	bute to the		eath? Inknown
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OT VITAL MOPYSICIAN: The This certificate his all director, page	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea		.,			
ding Phys ding Phys h. After this funeral dir	ilon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		f 28c. Injur Wor	er: 4 X Nursing Ho / at <br Yes 2 □ No		dence 6 Othe			
그 호텔 등 드	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, str (Specify)			28f. Location (S City or Tow	Street and Numbe m, State)	r or Rural	Route Numb	)er,
To the Hospital within 24 hours a To the Funaral I completely filled	edical C		ysician: To the best of niner: On the basis of e and manner state	examination and/or in							
To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed		ay, Year)	
		Nathan	7		04	7094		576	104		
VADQ		30. Name and address of person who	,	ath (Item 23a) (Type,	Spark	510N 57	REET	SAUSA	V RY	MD 2/	804
Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 6 2	32. Registrar	s Signature	Sport	N 1					

State of Maryland / Department of Health and Mental Hygiene 2004 16840 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 0235 M Irons Milton 05 21 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heart Hospital Allegany Sacred Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jan 6, 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□F Months Days Hours Min. MD 212-24-0385 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is markad other than "neturel", or Items 23a or 28a-f show treumatic event, I've Medicul Exampler mainted at Cumberland MD Allegany Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 13305 Irons Mt. Road, SE USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1X☐Yes 2☐ No II Yes, Give K 1 Never Married 2 Married 1 Yes 2 No Year or Dates: Korea Specify: Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. PPG Industry Millwright 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill if Health and Mental H item 27 is marked ott Be John Milton Irons Mary Rosella Wigfield Irons 19a. Informant's Name/Relationship (Type, Print)
Bruce Irons
Son Rural Route Number, City or Town, State, Zip Code) 21502 19b. Mailing Address (Street and Number of 15704 Winchester Rd item 2 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Pages 1
Department of He
Importent: If iten
any injury or oth 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Davis Memorial Cemetery 5/24/2004 Cumberland MD 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 22. NanScarpellit Punellital Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. En yr the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or earl failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cluse (Final disease or condition resulting in death) Hodg Kins **Physician** Endstage/ 0 mo-5 /Medical Due to (or as an equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physicien Physician/Medical as esu esu IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 100 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 Yes 2 1 No Hospital or Attending Physician: : After this certifical funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient Medical Certification: To 2 ☐ EB/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Prive. Wagoner 925 Bishop Gary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 6 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month MAY 2004ª 12, **Physician** 6:00 AM T. JACKSON REBECCA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Nov • 25, 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 🏖 🗀 F 83 Yrs. Maryland 578-30-0556 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State rthan "natural", or Items 23a or 28a-f show the Medical Evaminer must be codified at 1 X Yes 2 No Directo Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 Chestnut Street, #214 20877 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. Domestic Home 7 la marked other traumatic avant. L 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Basil Taylor Sarah Neal 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876 19a. Informant's Name/Relationship (Type, Print) Department of Hears.
Department: If item 27 le 19220 Staley Bridge Rd., Germantown, MD Glenn Taylor (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/20/04 Gaithersburg, MD Emory Grove Cem. signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIC WEEK Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 Tyes 2 Ko 4□Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 ☐ Yes 2 2No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **Z**No 1 ☐ Yes 2 No 1 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Phpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To this 28c. Injury at Work? in by the funeral 27. Manner of Death 1 Matural 28b. Time of 28d. Describe how injury occurred After Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation s after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide filled 24 hours a Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha within 2 To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00057124 sers, MD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13219 Executive Park Ter., Germantown, MD 20874 Truong Bao, M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2004 Registrar MAY

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			Registrar AMEND#5perTI  1. Decedent's Name (First, Middle, L		MW,McCo		uncate of t	Jealii	2. Date of D			3. Time of Death
	Physicia	an	LILLIAN HARRIS						Month 5-5-	04 Day	Year	1:30 P. M
>	/Medic Examin		4e. Fecility Name (If not institution, g		oer)		4b. City, Town, or	Location of Dea	ilh	4c.	County of Deet	h
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	Director	-	Usuel Residence of Decedent		86				0-13-	-1/	Oh	io
	yland pow	-	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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	or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Co	untry?
	ath w	a l	2201 Colston Dr				20910		C* - V h		A. A. Race - Ame	rican Indian
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36	al', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 ☑ No	Specify:			Specify: W	hite
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Z	and 2 sealth ar		Sigmund J. Jacob	Dr. Silv	ver Spri	ng, M	D 20910	)				
re,	ten 2 theal tem 2		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of natory or other place	e)	Date	20c. Lo	cation - City or	Town, State
Ē	Pages nent of ant: If the		1 ☐ Burial 2 🖾 Cremation 3  1 ☐ Donation 5 ☐ Other (Spe		Ft.		oln Crem.	1 -	8-04		twood,	MD
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marks any injury or other traumatic once.		21. Signature of Funeral Service Lic	ensee			2. Name and Addres					
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			shock, or heart failure. List on	ly one cause on each	ch line.	. Do not en	er the mode or dysh	g, such as card	ac or respiratory	arrest,		Interval Between Onset and Death
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9 X	death certifics e attending pt id for use as ti	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregna	ncv		-			23d. Date of del	ivon
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o.		nyslo	1 □ Yes 2 ☑ No 9 □ Unknown	9☐ Unknov								
<b>Q</b> .	g	by Pt	Part II. Other significant condition	s contributing to dea	ath but not resu	alting in the u	inderlying cause giv	en in Part I.	23e. Dio	tobacco u	se contribute to	the cause of death?
rds	w require been sig should b	ed b	Dehydration						. 1	]Yes 2[	□No 3□Pr	obably 4X Unknown
Records,	G S C	plet							24a. We	is an	24b. Were au	itopsy findings available completion of cause of
	Th ate pag	Completed								formed?	death? 1 ☐ Yes	
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,			r / m	- NVID								
	3		30. Name and address of person w Suresh K. Gupta,					0 Silve	r Spring	, MD	20906	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Rg	gistrar's Signa		Spark			-		
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	Physici /Medio	al	Decedent's Name (First, Middle, Last)     Pauline J. Jakobow	Paulin	e R.		bowsk			5, 20°	04	12:15 A.M
	Examir	er	4a. Facility Name (It not institution, give s Shady Grove Advent	ist Hospi		Ro	cky111			M	Ontgome	
4.5	Funeral Director		5. Social Security Number 6. Sex 579-48-7103	7. Age	70		der 1 Year is Days	If Under 24 Hrs Hours Min	. (Month,	Birth Dey, Year 1, 19	33 Was	irthplace (State or Foreign Country) shington, D.C.
	ne Maryland 8e-f show	ector	10a. State 10b. County  Maryland Montgomer	у	10c. City, Towr	mac						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	ai Dir	10e. Street and Number 11739 Gainsborough	Road			Zip Code 20854				tizen of What ( Lted St	•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show many injury or other traumatic event, ite Medical Examinational be muiting at ance.	Completed by Funeral Director	11. Marital Status  1 ☐ Nøver Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:			cedent of His pecify Cuban 2 X No	panic Origin? (§ , Mexican, Puer Specify:	Specity Yes or to Rican, etc.)	No-	14. Race - An Black, Wh Specify: T	
21215-0036	within 72 ho ene. then "natur te wedical	ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			Decedent's U (Give kind of life. DO NOT eacher	work done du	ion iring most of wo	rking		ind of Busines	,
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Mary	od 2 sho Ith and I 27 is ma trauma		19a. Informant's Name/Relationship (Ty) Walter Jakobowski/					nd Number or R				
Baltimore, Maryland	Pages 1 ar ment of Hea ant: if item ury or other		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Montgo	Disposition (A y, crematory o mery natoriu	m, Inc	. 2004	4	Bet	ocation - City o	Maryland
Balt	permit. Departimport any inj		21. Signature of Funeral Service License	M0135		Rockv	ille,	Marylan	<u>d 2085</u> (	) <del>-</del> 280:	phrey E gomery 5	uneral Home/ Avenue
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Acute My		ous Leu		such as cardia	c or respiratory	/ arrest,		Approximate Interval Between Onset and Death
3760,	eath certificate be executed attending physician and for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of							
P.O. Box 68	that the death certificated by the attending placed by the attending placed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1∐Live birth 2 4∏Pregnant at t 9∏Unknown	2 ☐ Fetal death	3 Ectopid					23d. Date of d Month	elivery Day Year
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Division of Vital Records,	ng Phys fter this ineral di	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 X Inpatier 28a. Date of Injury (Month, Day		tpatient 3 ime of nijury	DOA Other 28c. Injury a Work?	at	ath (Check online) Home 5 Re 28d. Describ	sidence		ecify)
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	e Hospi 24 hou e Funer letely fill	edical	29a. Certifier (Check only one)  1 Certifying Physical Exemination (Check only one)	ician: To the best of er: On the basis of and manner stat	examination and	, death occurred/or investigati	ed at the time on, in my opi	, date and place nion, death occ	e, and due to the time	ne cause(s e, date and	) and manner and du	as stated. ue to the cause(s)
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	10		30. Name and address of person who to Joseph Kaplan, M.D.	., 18111	Prince		Dr., (	Olney, 1	Marylan	d 208	32	
¢ř.	Sta Regist		31. Date filed (Month, Day, Year)  MAY 1 0 200	32. Registra	r's Signature		ach		-			

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Source   Properties   Propert		Examin	ei				#212					na			
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When Plastations of Decedent   100. City Town of Location   100. State of Other 20th   100. State of				241-78-2389	M 21XF	80	Yrs.	Months	Days	Hours	Min.	$\text{Aug.}^{(Month, Dev)}$	,1923	S.	Carolin
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State 31. Date liked (World), Day, Today	•	2/		1 total	- M	(1)			051	616			051	02	2004
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	R			31. Date filed (Month, Day, Year)	32. Rg			-			<b>V</b> /\\!	11301	-1,227	1/0[_	D 0-00 J2

DHMH 17 Rev 1/2001

			1 - For State Registrar		f Maryland		artmen rtificate			and M		giene Reg. No.	004	16845
	Physici		1. Decedent's Name (First, Middle, La Mabel T. Jones	st)							2. Date of Dea Month May 7,	2004	Year	3. Time of Death 4:10 P. M
and the second	/Medio		4a. Facility Name (If not institution, giv 2720 Snow Hill		mber)		Giı	rdlet				4c. Cou	nty of Death	h
	Funeral Director		5. Social Security Number 6. S 219-05-9126	eх □м <b>2</b> Ю F	7. Age (In yrs. la 83	Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Birtl (Month, Day 8-2-192	y, Year)	9. Birth Con	hplace (State or Foreign untry) Va.
	hours after death with the Maryland turel', or flems 23a or 28a-f show all Exercities must be notified at	ector	10a. State 10b. County  Md. Worcest	er		Town or Lo	cee							10d. Inside City Limits XX Yes 2 □ No
	sath with the 23a or 2	Funeral Director	10e. Street and Number 2720 Snow Hill I		edost Ever is II S	142		1829		i-0 (0-		10g. Citizen	1	
9036	rours after de rrai', or ttem LExamiliaer	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 Tes If Yes, Giv Year or D	2 [XNo		Yas Deced f Yes, spec		Spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	E	Black, White	rican Indian, o, etc. nite
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 is marked other than *natural; or items 23a or 28a-f show other traumatic event. Ite M. Alcal Exir. inter must be notified at	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)		-4or 5+)		lent's Usua kind of wor DO NOT us omemal	k done di e retired)	tion uring most	of worki	ng	16b. Kind of		ndustry
yland	ould be file Mental Hygurked othe	To Be C	17. Father's Name (First, Middle, Last) Charles Taylor						Laur	а Та	(First, Middle, rr Tayl	or		
e, Mar	1 and 2 sh Health and em 27 ls m		19a. Informant's Name/Relationship ( Sandra I. Hudson 20a. Method of Disposition	, ,			Box :	185 (	Gird1	etre	e, Md.			
Baltimore,	t. Page rtment c rtant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification)	()	State	nghil	L Cem	eter	y 5	-11-		Girdle		
B B	Dep dim dens one	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Short Funeral Hom 13 E. Grove St. I  23a. Part 1. Enter the disease, or consolications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one dause on each line.										. 1994 est,	40	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Met	cestation or as a conseque	1	CONCI	-	i i		cer			Interval Between Onset and Death
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	or as a conseque									
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P.O. B	that the death certific ed by the attending p detached for use as	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ M6 9 ☐ Unknown	4□Pregna 9□Unkno		ith 5□	Ectopic pre Other (spe	cify)				٨	Month	Day Year
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al Rec		e Completed	25. Was case referred to medical								24a. Was ar autops perform 1 Yes 2	ned?	death?	opsy findings available impletion of cause of
Division of Vital Records,	Attending Physician: The la r death. ector: After this certificate ha: by the funeral director, page 2	ToB	27. Manner of Death  1 Matural 5 Pending		77.7	R/Outpatient 8b. Time of Injury		Other	4 □ Nur	sing Hom	(Check only only only only only only only only	nce 6 🗆 O		(5)
Divisio	를 를 들	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At hom ig, etc. <i>(Specify)</i>	e, farm, stre	et, factory,		es 2⊡N		8f. Location (Str City or Town	reet and Nun , State)	nber or Rure	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifying Phyone 1 Medical Exem	/sicien: To the liner: On the ba and mann	sis of examinatio	edge, death in and/or inv	estigation, i	n my opii	nion, death	place, a	d at the time, da	ite and place	, and due to	o the cause(s)
)	T wit	N C	29b. Signature and title of certifier  30. Name and address of person who of	ampleted cause	of death (low o	) (Tuna 1	1	D 2		78			10-0	04
Q -	Sta	te	DAVID COUNTY) 31. Date filed (Month, Day, Yeer)	10 / 5 32. Re	gistrar's Signatur	ARK	GLL	-5,	7	51	1451	BURY	, pe	D 21801
	Registra	ar	MAY 1 0 20	104	repeva	B	Spo	rela	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reuben G. King State of Maryland / Department of Health and Mental Hygiene 04-3021 AKG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Reuben Garrick King May 3 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's

9. Birthplace (State or Foreign Country)
Illinois Upper Inder TYear ths Days 8510 Grandhaven Avenue 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Hours Months 1 XM 2 □ F 354-60-7476 33 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-1 show 10b. County 10c. City. Town or Location 10a. State if Health and Mental Hyglene. Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at Prince George's Upper Marlboro Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 United States 3305 Spriggs Request Way Completed by Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates: unknown 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Fed-Ex Delivery Carrier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elvis Houston Robert King 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10207 Baltimore Ave., # 8408, College Park, Md. Ivan King (Brother) 20b. Place of Disposition (Name of programmer place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its any injury or ot Physician /Medical **Examiner** burial-transit

To tha Hospital or Attanding Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Funaral C

'4 □ Donation 5 □ Other (Spec		Cremato		5-10-2004	Riverdal	e, Md.
21. Signature of Funda Service Lie	Dycen	22. Na S: 5	me and Address of Fa nead's Fund 732 Georgia	eral Home and a Ave., N.W.,	Cremation Wash., D.	Services C. 20011
23a. Part1. Enter the disease, or co shock, or heart failure. List on	mblications that caused the ly one cause do each line.				rest,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as		ead to H	2 of		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	consequence of):				
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d	consequence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3 Ect	opic pregnancy ner (specify)		23d. Date of de Month	alivery Day Year
Part II. Other significant conditions	contributing to death but	not resulting in the under	lying cause given in Pa		bacco use contribute t es 2 □ No 3 □ P	to the cause of death? Probably 4 Kinknown
				24a. Was a autops perfort	sy prior to med? death?	utopsy findings available completion of cause of s 2 \sum No
25. Was case referred to medical			26. Pla	ace of Death (Check only on	18)	
examiner? 1 <b>∑X</b> es 2□No	Hospital: 1 Inpatient	2 ER/Outpatient 3	DOA Cther: 4	Nursing Home 5 Reside	ence 6 🖫 Other (Sp	ecify) At scene
27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	9 13 10 1	28b. Time of Injury	28c. Injury at Work?  M 1 Tyes 2	28d. Describe ho	ow injury occurred Slut sel	4
3  Suicide 6  Could not determine	be 28e. Place of Injury building, etc.	(Specify) ST/Con	factory, office	28f. Location (Si City or Town Avenue, 1	treet and Number of Fin. State) 8570	ivral Route Number, Trandhaven projeto, Menular
		xamination and/or investi		and place, and due to the codeath occurred at the time, d	ause(s) and manner a	s stated.
29b. Signature and title of certifier			29c. License numbe	er 2	29d. Date signed (Mon	th, Day, Year)
1 Leodon	M. King .	eus	O.C.M.E.		May 4, 200	)4
30. Name and address of person wh		th (Item 23a) (Type, Prin	t)			
THEODORE MIKE	7	1	11 Penn St	reet, Baltimo	ore, Maryla	and 21201
31. Date filed (Month, Day, Year)	32. Registrar'	s Signature	books			
MAY II 2	004 Sener	N	itions.			

7:39 P

10d. Inside City Limits

Black

1 ☐ Yes 2X No

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Registrar

within 24 h

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	/Medic	al				<u> </u>	4h City Toy	m or Location	a of Dooth	May 6	-	O 4 County of De	1:45	P
	Examin	er	4a. Facility Name (If not institution			-		vn, or Locatio			40.	•		
			Frederick Me 5, Social Security Number		OSP1ta Age (In yrs. la			deric Mear   If Unc	K ler 24 Hrs.	8. Date of Bi	rth	Fred	derick Birthplace (State or	r Foreian
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			Usual Residence of Decedent				1			INDIAL	J, -	7 2 7 1.	11000011	
	rylan		10a. State 10b. County			, Town or Lo				è			10d. Inside Cit	
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	ath w		10111 Central	#211				64114				ted St		
	tems tems	Funerai	11. Marital Status	12. Was Decede	es?	S.   13.	If Yes, specify	of Hispanic Cuban, Mexi	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	0-	Black, W	merican Indian, hite, etc.	
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b	be filed tal Hygi d other event.	Be	17. Father's Name (First, Middle,	Last)				18. Mc	ther's Nam	e (First, Middle	-	Sumame)		
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Ba	permit. Departr Importa any inji				_ )	To	rchins	ky Heb	rew F	uneral				
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	Dharistan		shock, or heart lailure. List Immediate Cause (Final	only one cause on eac	n line.		1 /	1	0	./			Onset and D	
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<u>α</u>	that sed b		Part II. Other significant conditi	ons contributing to deat	th but not resu	ılting in the u	underlying caus	e given in Pa	rt I.	23e. Did	tobacco u	se contribute	to the cause of de	eath?
rds	quires n sign	ed by						- <del></del>		1 🗆	Yes 2	XNo 3□	Probably 4 U	nknown
Records,	sw requir s been si s should	ompieted								24a. Was			autopsy findings a	
Re	The lav	E O								auto perfe 1 ☐ Yes	ormed2 2 No	death		use of
Vital	sician: Th certificate rector, pag	BeC	25. Was case referred to medica	ıl				26. PI	ace of Dea	th (Check only	<del>/-&gt;-</del>			
of V	d s	10	examiner? 1 Ves 2 No	Hospital: 1 ☐ Inp		ER/Outpatie	nt 3 DOA	Other: 4	Nursing H	ome 5 Res	idence (	3 □Other (S	pecify)	
		ü	27. Manner of Death 1 ★Natural 5 ☐ Pendir	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe	how injur	y occurred		
sio	a # :: 0	cati	Z Accident investi	igation not be			М	1 Yes 2	□No					
Division	or Attendated after death Director:	Certification:	4 Homicide determ	nined 289. Place of	I Injury - At ho , etc. (Specify	me, Jarm, st	treet, Jactory, o	fice			wn, State		Rural Route Numb	)er,
	pital ours a eral (		29a. Certifier J□ Cartifyi	ng Physician: To the be	act of my know	wledge dea	th occurred at t	ho time, date	and place	and due to the	031150/5)	and manner	as stated	
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	edical		Examinar: On the basi and manner	is of examinat	ion and/or is	avactication in	my opinion	tooth accur	rod at the time	data and	place and d	luo to the seuse/e)	
	ro the vithin ro the complex c	Me	29b. Signature and title of certifie	er 0//	) ,		29c. L	icense numb	er		29d. Dat	e signed (Mo	inth, Day, Year)	
	10		1 Alan	2 Ho	Linea	M	NI	37	19	7	5	-7	2004	
	10	1	0 - 000	1	0001	1 2	1 )							
	10		30. Name and address of person	who completed cause	of death (Item	23a) (Type	, Print)		,	4-		1	1 1	
_	10		Alan 4	Kohre	er M	23a) (Type	, Print) /56	Vest	7	454.	Fre	deri	ckMD2	21703
	Sta Registr		30. Name and address of person 31. Date filed (Month, Day, Year,	Kohre	of death (Item	23a) (Type	Soon	Vest K	フェ	454.	Fre	deri	inth, Day, Year)	21703

			1 = For State Registrar	State of Ma			artmer	t of H			•	gien	200	الم	16848
-	Physici /Medio		Decedent's Name (First, Middle, Last)     Bruce Albert Knox								2. Date of De Month May	1,	2004	9	Time of Death
*	Examir	er	4a. Facility Name (If not institution, give st	reet and number)					Location o	of Death		4	c. County of De		
			1133 Zehner Road  5. Social Security Number 6. Sex	7. Age	(In vrs.	last birthday)		ntsv r 1 Year	If Under:	24 Hrs.	8. Date of Bi	rth	Garrett		(State or Foreign
	Funeral Director			M 2□F	67	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di June 1	O, 1	936 Ma	country)	(State or Foreign
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation								nside City Limits
	death with the Maryland ms 23a or 28a-f show rioust be notified at	ctor	Maryland Garrett		G	rantsv	ille								Yes 2∏No
	with th	Dire	10e. Street and Number					Code				-	itizen of What C	Country?	
	eath v	erai	1133 Zehner Road	2. Was Decedent E	ver in U	S 13		1536		nin? (Spe	city Yes or N		JSA 14. Race - Am	nerican In	ndian.
36	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "natural", or Items 23a or 28a-f show event, if a Mydical Exand ser must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 XYes 2 N If Yes, Give Year or Dates:		54-	If Yes, spe			, Puerto	ecify Yes or N Rican, etc.)		Black, Wh Specify: Whj	nite, etc.	
2-0036	2 hou		15. Decedent's Educ	ation		16a, Dece	dent's Usu	al Occupa	ation	e of work		16b.	Kind of Busines	s/Industr	у
215	within 72 ene. then "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT L	se retired	turing most	t of work!	ng				
Maryland 2121	filed wil Hygien other th	Con	10			Carpe	nter						pentry		
ng	be file	Be	17. Father's Name (First, Middle, Last)								(First, Middle		_		
2	should be and Mental marked o	2	Harvey Knox  19a. Informant's Name/Relationship (Type	a Print)		19b Mailie	na Addres	S /Street :		_	rgaret		ephens or Town, State,	Zin Cod	(a)
Z Z	d 2 s th ar 7 is trau		Frances Dale Knox/W			1	•						aryland	215	
ē,	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of	-1		ate		Location - City of		
JOE	Pages nent of int; if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		intry S	-		1918	ay 5	2004	Dan	idsvill	o D	λ
Baltimore,	1 5 E E		21. Signature of Funeral Service License	9	S					Ylorac	s, P.A		TOSVITI	er r	n
ä	Depa Impo		1 Dan D	lyma	~						s, P.A sville		21536	5.	
)	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failers. List only on Immediate Cause (Final disease or condition resulting in death)		e. 3 R	h. Do not ent	ter the mo	de of dyin	g, such as	cardiac c	or respiratory a	arrest,	aulen	Into	proximate erval Between set and Death
6	Examiner	ner	Sequentially list conditions, is any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	ı conseq	uence of).									
,092	cate be executed physician and s the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	conseq	uence of):									441 141 141
P.O. Box 68	ath certif tending or use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 1 9 □ Unknown	2 🗌 Feta	Ideath 3	⊒Ectopic p □ Other (s						23d. Date of d	elivery Day	Year
	uires that the de n signed by the a lid be detached f		Part II. Other significant conditions conf	ributing to death bu	it not res	ulting in the u	ınderlying	cause give	en in Part I.				use contribute		use of death?
OS	w requir been si should	iete									24a. Was		24b. Were a	autopsy fi	indings available
Re	ician: The lav certificate has ector, page 2	Completed										ormed?	prior to death?	o complet	tion of cause of
ta	an: T tificat tor, p	Be C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes		10 10 16		NO
>	ysici is cer direct	To B	examiner? Yes 2 No	ospital: 1 Inpatier	nt 2 🗆	ER/Outpaties	nt 3 D	Othe					6 □Other (Sp	pecify)	
0	eg Phys ter this neral di	L:u	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Yeer)	28b. Time o	of	28c. Injury Work			28d. Describe	how inj	ury occurred		
Division of Vital Records,	after death. Director: After	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ıry - At h	ome, farm, st	M reet, factor	10	Yes 2□	-	28f. Location (		and Number or F te)	Rural Rou	ıte Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier  (Check only one)  1 Certifying Phys 2 Medicel Exemin		examina										
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License	number				ate signed (Mor		
	F 5 F 0		P Danux	male and of the	ath (line	Je 17:00		, .	615				5/57	104	
			30. Name and address of person who could be a second of the second of th	32. Registra			Ae	ve s	Dr	ino	Oal	da	nd M	02	550
	Sta	ate	MAY = 3	2004	July Oigila	Ast.	A.	25							

			1- State of Maryland / Department of H Certificate of L	lealth and M Death		giene Reg. No. 200	l 16850
	_		Decedent's Name (First, Middle, Last)		2. Date of De	ath	3. Time of Death
	Physici		GEORGE ANTHONY KNOUS		Month	06 04	/ I
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death		4c. County of De	1.0
			DENINGULA DECIONAL MEDICAL CENTER SALISE	RIDV		WICC	MTCO
	Funeral		Months Days	Hours Min.	8. Date of Birt (Month, Da 02-01-		MTCO hirthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		02-01-	1943 HOU	STON, TX.
	/land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Marylar 28a-f show	to	MD WICOMICO SALISBURY				M∑Yes 2 □ No
	vith the Maryla or 28a-f shor be notiting at	lred	10e. Street and Number 10f. Zip Code			10g. Citizen of What	Country?
	23a c	al		1804		USA	
	ltems Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Ai Black, W	nerican Indian, hite, etc.
36	rs afte	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No No No No No No No No No No No No No	Specify:		Specify: W	HITE
윽	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28a-f show ent, the Medical Exercitran the notified at	edt	15. Decedent's Education 16a, Decedent's Usual Occupa	ation		16b. Kind of Busine	ss/Industry
215	d within 72 ho piene. r than "natur the Medical	Completed	(Specify only highest grade completed)  (Give kind of work done of life. DO NOT use retired.  Elementary/Secondary (0-12)  College (1-4or 5+)	during most of worki I)	ing		
213	od with	E C	7 CARPENTER	<b>L</b>		CONSTR	UCTION
pu	be filed tal Hygi d other	Be (	17. Father's Name (First, Middle, Last)			Maiden Sumame)	
<u>√</u>	2 should be and Mental is marked o	ို		LOLA EVAN			
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Address ( <i>Street a</i> FMTLY KNOUS - SPOUSE 5881 HAMMOND S				
_	s 1 and 2 should be filed if Health and Menta Hyg Item 27 is marked othe other traumatic event,		20a Method of Disposition 20b. Place of Disposition (Name of		ate	20c. Location - City	
JO TO	m O - 1.		1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)	θ) 05-11-	-200/-	SALISBURY,	
Baltimore,		1	21. Signature of Funeral Service Licensee 22. Name and Address				
B	permit. Depertr Importe any Inju		705 EAST MA				
			23a Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on early line.				Approximate Interval Between
	Pnysician	87 -		nosis			Onset and Death
~	/Medical		resulting in death)  Due to (or as a consequence of):	110013			
-68-8872 30,	Examiner	L	Sequentially list conditions, b.				
\$	ed slt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
00	be executed sician and burial-transit	xan	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
Ψ.	The law requires that the death certificate be executed to has been signed by the attending physician and begee 2 should be deteched for use as the burial-transit						
687	ifficate g phys as the	Physician/Medical					
y XO	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of d	*
S G	ne deat the att hed for	Sicia	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5 Other (specify)		<del></del>	Month	Day Year
2 O. P.	that the de ed by the deteched	Phy	9 Unknown		22a Dida		to the cause of death?
ds,	ires tha signed I be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en ar Farti.	1 1	L./	Probably 4 []Unknown
A 20	w require been si should I	etec	- Christer gophing		-		
A. Rec	The law ate has I pege 2 s	Completed			24a. Was autop perfo	an 240. Were prior to death	autopsy findings available o completion of cause of ?
a is		ပို	25. Was case referred to medical	OC Plans of Parall	1 Yes	2 No 1 □ Y	es 212 No
512		To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	26. Place of Death		nne) dence 6 ⊡Other(Si	necify)
0	ding Phys		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury			now injury occurred	, activity
3 0	uttending F death. ctor: After y the funer	atio	2 ☐ Accident investigation M 1 ☐ Y	Yes 2 □No			
Division	after dea after dea Director	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
٥	Hospitel or Attending 44 hours after death. Funeral Director: After tely filled in by the fune	O					
	Hospitel     24 hours a     Funeral letely filled	edicai	29a. Certifier (Check only one)  Check only one)  [Check only on	ne, date and place, a pinion, death occurr	and due to the o ed at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the Hosp within 24 ho To the Fund completely f	Med	29b. Signature and title of certifier 29c. License	e number		29d. Date signed (Mo	nth, Day, Year)
	p- ≰ p- ō		Dan:	3-2-2/-3	,	5/7	104
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				10/
200	λ		Stephen Kein 100 E. Carroll St. S	alisbur	y, MI	5   7 0 2/80/	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	61	, .		
	Registi	rair	MAY 1 0 2004 Serve & Space	-			

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Box (	iboo daa
P.O.	ho tho d
on of Vital Records, P.O. Box 687	to a long and a second
Vital	
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Division	

	1		State of Maryla					ental Hy	giene	PANI.	10051
	,		State Registrar	Ce	rtificate o	t De		2. Date of De	Reg. No. C	.004	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Last)     MARY LOUISE LANCAST	FD				Month 0.5	Day 2 0	Year 2004	6:33P M
	/Medio Examin		4e. Facility Name (If not institution, give street and number)	DI	4b. City, Town	n, or Lo	cation of Death	05		ounty of Death	0:331
	Examili	iei	Civista Medical Center		La Pl	lat	а		Ch	ar1es	
	Funeral		5. Social Security Number 6. Sex 7. Age (In y.	rs. last birthday	Months Day		Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	th y, Year)	9. Birth	olece (State or Foreign ntry)
	Director		217-20-2322 1 M 2 X V Usual Residence of Decedent	77 Yrs.			A	PR.27	<u>, 192</u>	7 MARY	<u>/LAND</u>
	land ow			City, Town or L	ocation.					Ţ.	10d. Inside City Limits
	Many a-f sh	io	MARYLAND CHARLES		L	A.	PLATA				1 ☐ Yes 2 ☐ No
	ith the or 28	Oire	10e. Street and Number		10f. Zip Code		4.6		_	n of What Cou	-
	ath w	rail	1 MAGNOLIA DRIVE		Į.	206		efy Vac or No		U . S . A .	
er	1215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show then "hat would be noullised at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ No	10.5.	If Yes, specify C	uban,	anic Origin? (Spec Mexican, Puerto R	lican, etc.)	, ,	Black, White,	
aste	urs af	by F	If Yes, Give X Year or Dates:		1□Yes 2√√2N	No .	Specify:		S	pecity: BI	LACK
Cas	5-0036 72 hours aft	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occ e kind of work do	ne dur	on ing most of workin	g	16b. Kind	of Business/In	ndustry
	within iene.	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	life.	PRES		D		Τ. Δ	UNDRY	CO
-	Ind 2		O 17. Father's Name (First, Middle, Last)		FRED	-	3. Mother's Name	(First, Middle			CO.
г. П	F 2 2 5 9	To Be	CHARLES DENNIS LANCAS	TER			MARY	AMEL	IA Q	UEEN	
A	re, Maryla 1 and 2 should 1 Health and Men 1 tem 27 is marke other traumatic	-	19a. Informant's Name/Relationship (Type, Print)				d Number or Rural				o Code)
lar	te, M		MARY GLORIA SWANN-DAUGHTE				FAULKN	ER, MD		632 Ition - City or T	oue State
Σ	0 0		1 Neurial 2 Cremation 3 Removal from State	cemetery, cri	oosition (Name of ematory or other p	place)	l l				
	Baltimo		4 □ Donation 5 □ Other (Specify) ST ↓ I  21. Signature of Fugeral Service Licensee MOO 479	GNATI		4.4.	RY 5-26				MARYLAND
	Balt permit. Departr Importa		D. 1. 00.7	V	RAYMON	$^{1D}$	FUNERAL ,MARYLA	SERV	ICE,	P • A •	
	\$		23a. Pen1. Enter the disease, or complications that caused the d shock, or hear failure. List only one cause on each line.	eath. Do not e	nter the mode of o	dying,	such as cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ACUT	E 9	ASTR	O	NTES	TINA	-LB	LEED	Onset and Death
	/Medical Examiner		resulting in death)  Due to lor as a con-	sequence of):							4.00
$\sim$	Lxammer	<b>a</b>	Sequentially list numbrons b. Due to (or as a con:	sequence of:	u	L (	CER				IKS
(ha)	nsit	Examiner	Sequentially list conditions by the first conditions by the first conditions by the first cause. Enter Underlying Cause (Disease or injury that initiated events c.								
WP	'60, be executed sicien and burial-transit		resulting in death) Last C. Due to (or as a con-	sequence of):							
	8760, sate be executed shysicien and the burial-transit	dicai	d								
	c 68 artifica ing ph	Med	IF FEMALE:					=			
	of Vital Records, P.O. Box 68 Physician: The law requires that the death certifies this certificate has been signed by the attending phraid director. page 2 should be detached for use as the	Physician/Me	23b. Was decedent pregnant	etel death 3	Ectopic pregna				23	<li>d. Date of delive Month</li>	rery Day Year
	that the de detached is	ysic	in the past 12 months?  1 Yes 2 No 9 Unknown	Or Geatti S	U Other (specify)	'/					
	dS, P.	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause	given	in Part I.	23e. Did 1	obacco use	ontribute to	the cause of death?
	cords w requires been sig	ed b	DEMENTIA					10	Yes 2□	No 3□Pro	bably 4 Unknown
	ecordiaw requias been 2 shoulk	Completed						24a. Was	psv	24b. Were auto prior to co	opsy findings available ompletion of cause of
	The The page	Com						perfo	ormed? 250No	death? 1 ☐ Yes	2 □ No
	Vital Recition: The law	Be	25. Was case referred to medical examiner?		1	Other:	26. Place of Death				
	Of Phys	. To	1 ☐ Yes 2 No 1 ☐ Inpatient :  27. Manner of Death 28a. Date of Injury (Month, Day Yea	2 P/Outpati 28b. Time	ent 3 DOA	injury a Work?	4   Nursing non	ne 5∐ Resi !8d. Describe			(fy)
	on rding th. : Afte	tion	1 Natural 5 Pending (Month, Day Yea 2 Accident investigation	r) Injury			s 2 No				
	Division of Vital Records, for Attending Physician: The law requires thater death.  Director: After this certificate has been signed in by the funeral director, page 2 should be on the property of the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - building, etc. (Sp	At home, farm, :	street, factory, offi	fice	2	8f. Location (	Street and wn, State)	Number or Rur	al Route Number,
	Distance is after all Direction in Bed in	Cert									
	Division of Vital Rewittending Physician: The lawthin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Physician: To the best of my (Check only one) Medical Examiner: On the basis of exam and manner stated.								
	thin 2 the the omple	Med	one) and manner stated.  29b. Signature and title of dentifier		29c. Lic	cense r	number		29d. Date	signed (Month	. Dey, Year)
	F 3 F 3		> 1/ Loan SHO	ENDIN	D-	-444	436		May	121	2004
	4		30. Name and aduless of person who completed cause of death	(Item 23a) (Typ		( -1 '			-		7007
	1		Ashvinkumar J. Patel,MD		ul Mel	101	n Ct. S	te. 1	02 Wa	ldorf	,MD20602
	100	tate	31. Date filed (Month, Day, Year)  32. Registrar's S	ignature	/		4				
	Regis	trar	MAY 2 6 2004 Belive		boar.	1					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrar		f Marylar		artment o				Reg. No	20	04	16	852
	Physicia	an	Decedent's Name (First, Middle     DERA			T D 4 57	- mm			2. Date of De Month	Day		ear	3. Time o	
	/Medic		REBA 4a. Facility Name (If not institution	JUDITE		LEAV		n, or Location	of Death	MAY 9,		)4 County of	Death	4:15	P M
	Examin	er	1111 UNIVERSIT			512		ER SPRI				40NTG0		Y	
F	uneral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da	ear If Under	24 Hrs. Min.	8. Date of Bir (Month, Da				ace (State o	or Foreign
D	irector	}	172-05-3109 Usual Residence of Decedent	1□M 2∏F	88	Yrs.				SEPT 7	, 19	915 E		ŚYLVA	
land	MO N		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10	d. Inside C	ity Limits
э Мал	a-f sh liftied	ctor	MARYLAND MONT	GOMERY		SILVER	SPRING							1 X Yes	2 🗌 No
ith the	or 28	Director	10e. Street and Number				10f. Zip Cod	le			10g. Cit	izen of Wha	at Count	try?	
ath w	s 23a		1111 UNIVERSIT				2.090					TED S			
ter de	tem nar	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Marri	Armed Fo		J.S. 13.	Was Decedent If Yes, specify (	of Hispanic Or Cuban, Mexica	igin? (Spe n, Puerto	cify Yes or No Rican, etc.)	-	14. Race Black, \			
<b>5-0036</b> 72 hours after death with the Maryland	al', or	þ	3 \ Widowed 4 □ Divorced	If Yes Giv	/e		1□Yes 2☒	No Specify	:			Specify:	WHT'	TE	
21215-0036  Multhin 72 hours aff	dical	Completed	15. Deceden	nt's Education st grade completed)		(Give	dent's Usual Oc kind of work do	ne durina mo:	st of worki	na	16b. K	ind of Busin	ess/Ind	ustry	
within	han a	mpk	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use re	tired)				COME			
d 2 filed v	ther t	e Co	17. Father's Name (First, Middle,	Last)		CLE	CK.	18. Moth	er's Name	(First, Middle,		GOMER	CY C	OUNTY	
an le be	ked o	To B	HARRY	BLUM					ILLI			JACO	BS		
lary should	s mar		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Str	eet and Numb	er or Rura	l Route Numbe	er, City o			Code)	
	or results any wenter rygenic and the matter of thems 23a or 28a-f show them 21a or 28a-f show the marked other than "natural", or their traumatic event, the Medical Examinar must be notified at		SANDRA L. LERN	ER, DAUGH			STONE								
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		State	cemetery, crer	sition (Name of natory or other	place)		ate		cation - Cit	•		
Baltimo	portant: If ite		* 4 □ Dopation 5 □ Other (S 21. Signature of Funers Service		JU	DEAN M	EMORIAL	GDNS   1	1 YAP	1, 200	÷ 01	LNEY,	MAR	YLAND	
Ba	any i		ares	The An	~	EÎ	Name and Ad WARD SA	AGEL FU	NERAI	DIREC	TION	, INC		0.50	
			23a. Pagn. Enter the disease, or	complications that c	aused the deat		91 ROCE or the mode of					., MD		852 Approximat	e
Phy	sician :		shock, or heart failure. List Immediate Cause (Final disease or condition		ROVASCI	TIAD AC	CIDENT							Interval Bet Onset and	
/M	ledical		resulting in death)		or as a consec		CIDENT						2	DAYS	
Exa	aminer		Sequentially list conditions	0			RDTOVAS	CULAR	DISE	ASE			10	) YEAI	RS
pe	ısıt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consec	quence of):									
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760,	nysician and he burial-transit	calE		d									ı,		
	as th		IF FELLY C												
. Box 68 death certifica	attending prider use as the	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1 ☐ Live b	come of pregna		Ectopic pregna	incy			1	23d. Date of Month		•	Year
	the al	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of o	leath 5□	Other (specify	)				MOUTH		Jay	i bai
<b>□</b> ig	ed by the a	Ph	Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the u	nderlying cause	given in Part I		23e. Did to	obacco u	se contribu	te to the	cause of c	leath?
ds,	5.0	d by								101	res 2(	_No 3 [	Proba	bly 4 ⊡t	Jnknown
Vital Record sician: The law requir	s been s	ompieted								24a. Was				sy findings	
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ia :	∯ '5	BeC	25. Was case referred to medica examiner?						e of Death	(Check only o					
of Vita Physician:	this cert ral direct	P	1 ☐ Yes 2 ☑ No		npatient 2		I 3 DOA			ne 5∑ Resid			Specify)		
	After	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	19	th, Day Year)	28b. Time of Injury	1	njury at Work? I □ Yes 2 □		.8d. Describe h	now injur	y occurred			
Division For Attending	Director:	ertification;	2 Accident investi 3 Suicide 6 Could	not be gen Blace	of Injury - At h	ome, farm, str	eet, factory, offi			8f. Location (S	Street an	d Number o	r Rural .	Route Num	ber.
5 5	l Dire	Certi	4 ☐ Homicide determ	buildir	ng, etc. <i>(Specil</i>	(y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tou	vn, State,	)			
the Hospital or	To the Funeral Director: completely filled in by the	edicai (	29a. Certifier 1 ☐ Certifyir (Check only one)	ng Physicien: To the Exeminer: On the ba and mann	best of my kno asis of examina ner stated.	owledge, death	n occurred at the vestigation, in m	e time, date ar ny opinion, dea	nd place, a th occurre	and due to the o	cause(s) date and	and manne place, and	r as sta due to t	ted. he cause(s	)
Toth	To the complet	M	29b. Signature and title of certifie	or	14.1		29c. Lic	ense number			29d. Dat	e signed (M	fonth, D	ay, Year)	
	6		Collin		VAL	7		D17890			MAY	10, 2	004		
	•		JON M. WISEMAN,		-		-	T. NT. T	TA 077-	MORO:-	T. C	0.00	_		
	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ature /	T AVENU		WASHI	NGTON,	DC_	2001	5		
	Registra		MAY 11	L 2004	Genera	13	spar	Kal							

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Stella M. Levin May 12, 2004 7:15 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death **Examiner** 14013 Burning Bush Lane Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Jan. 24, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2₩F Yrs. 307-03-9265 86 1918 Indiana **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r items 23a or 28a-f show inerr unt be netified at 1 ☐ Yes 2 X No Silver Spring Funeral Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 14013 Burning Bush Lane U. S. A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23ary or other traumatic event, the Modical Exx. interiouslating. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DD NDT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 2 Years Accounting Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bessie Miller Max Mandel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stefanie L. Margulies, Dgt. 17925 Ednor View Terrace, Ashton, Md. 20861 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ou ouce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Garden 5/14/2004Falls Church, Virginia <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHTNOM S Priysician CANCE R disease or condition resulting in death) Due to (or as a consequence of /Medical Hypertens ion Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury Due to (or as a consequency of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. the a 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy performe 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Accident Injury 5 Pending within 24 hours after deau..
To the Funeral Director: Alf 1 ☐ Yes 2 ☐ No hours after death. investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39190 MAY 13,2004 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Garrett Reilly, M. D. 3418 Olandwood Court, # 111, Olney, Md. 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 14 2004 Registrar

		·	For State Registrar	State of Ma				t of H	ealth a		lental Hyg	iene <sub>eg. No.</sub> 2 (	104	16854
	Physici	an	1. Decedent's Name (First, Middle, Last Alyne C. Ladd	)					_		2. Date of Deat May 1,		Year	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death		4c. County	of Death	5:35 P. <sup>M</sup>
			Goodwill Mennonit				-		svill				rett	
	Funeral Director		5. Social Security Number  334–28–8888  Usual Residence of Decedent	х 7. Age		ast birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Apr 29,	1911	9. Birthp Coun Cana	lace (Stete or Foreign itry) ada
	Maryland a-f show	tor	10a. State 10b. County FI. Monroe			r, Town or Lo rernie							1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 284	Direc	10e. Street and Number			<u> </u>	10f. Zip				1	0g. Citizen of	What Coun	itry?
	s 23a	rai	194 Airstream Lan	E 12, Was Decedent B	Suprin III	S 12 1	Mas Doord	330		oio? (Sp	acifu Voc or No	USA 14 Ba	ce - Americ	an Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Madical Exerting fruit be inclified at ODGe.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2  N If Yes, Give Year or Dates:			f Yes, spec			gint (Sp i, Puerto	ecify Yes or No- Rican, etc.)		ck, White,	
15-0	in 72 ho n "natur Nadical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		4)	16a. Deced (Give life. (	dent's Usua kind of wor OO NOT us	k done a	urina most	of work	ing	16b. Kind of B	usiness/Ind	dustry
212	er tha	Com	12	College (1-401 5	,	Arti	st					Art		
Maryland 21215-0036	wild be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last) Alfred Catto								Hurley	Maiden Sumar	ne)	
Man	alth and I		19a. Informant's Name/Relationship (T) Barbara A. Elster								al Route Number e, Deer l			Code) L550
Baltimore,	Pages 1 and of He not: If item into or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ I 1 ⁴ ☐ Donation 5 ☐ Other (Specify,		CE	lace of Dispo emetery, cren ntry S	natory or of	ther place				20c. Location Davids		
Balti	permit. Departrimporta any inju		21. Signature of Funeral Service Licens	ee	/						es,P.A., entsville			5
	/Medical Examiner	Examiner		a. OWLY Due to (or as a Due to (or as a	a consequ	n. Do not ent	er the mode	e of dying	g, such as	cardiac d	or respiratory arre	est,		Approximate Interval Between Onset and Death Curles
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or as a d	of pregna	ncy death 3	Ectopic pro						ate of delive	ory Day Year
	law requires that as been signed b 2 should be deta	d by PI	Part II. Other significant conditions co	ntributing to death but				-	n in Part I.		23e. Did tob	_	tribute to th	ne cause of death?
Division of Vital Records,	The law rex ate has bee page 2 shot	Completed by	hypertension	V, hypo	they	roidi	5121				24a. Was a autops perform	y ned?	Were autoprior to condeath?	psy findings available inpletion of cause of 2 No
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on of	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tlon: To	1 Yes 2 No  27. Menner of Death Natural 5 Pending Accident investigation	1 ☐ Inpatie 28a. Date of Injur (Month, Day	y	ER/Outpatien 28b. Time of Injury		8c. Injury Work	at		me 5 ☐ Reside 28d. Describe ho			()
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	10		30. Name and address of person who a mangaret a ki	iSER M	0	1307	Print)	Url	et 14	izhu	way a	aklen	ed, l	104
	Sta Regist		31. Date (jilled (Month, Day, Year) MAY - 4 20	32 Registra	ers Signa	k A								

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			1 - State Registrar			• • • • • • • • • • • • • • • • • • • •	Ce	rtificate of L	Death	F	leg. No.	U4	161	<u>855</u>
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	/Medic		Back Ok Lee							May 1			2:15	рм
15	Examir	ner	4a. Facility Name (If not institut						Location of Death		4c. County	of Death		
			Millennium N 5. Social Security Number	ursin 6. Sex			last birthday)	Ellicot	t City If Under 24 Hrs.	8. Date of Birth	Howa	rd Right	lana (Etnta a	r Foreign
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ţ <	G S	To B	examiner? 1 ☐ Yes 2/☐ No	Hospi	ital: 1 🔲 Inpa	tient 2 🗆	ER/Outpatien	t 3 DOA Othe	r /	me 5 Reside		(Specify	)	
			27. Manner of Death 1i☑Natural 5 ☐ Pend		Ba. Date of In	ijury Day Year)	28b. Time of Injury	28c. Injury Work	at :	28d. Describe ho	w injury occurre	d		
Sio	Attendir death. ctor: Al y the fu	atic	2 Accident inves	tigation					es 2□No					
Division	200	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 28	Be. Place of I building,	njury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f. Location (St. City or Town		or Rural	Route Numb	er,
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	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certif		_			29c. License	number	25	9d. Date signed	(Month, £	Day, Year)	
)	200		Januar	u to	aleh	am		12	8195		5/13/	DU		
1	2		30 Name and address of person	n who comple	eted cause of	death (Iten	n 23a) (Type,			Λ -	10	- 1	4,0	
<u>y</u> (	P		VASNEEM	CAK	HAT	VI, T	7220	TARK	HEIGH	53 HV	1 DA	eso	MIDZI	208
	Sta		31. Date filed (Month, Day, Yea	<sup>r)</sup> 2004	32 legis	strar's Signa	ture	a.N.	-					
	Registr	ar	WIP'S I	£ 2004		1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** MANIN na Felt. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** 10 If Under 1 Year If Under 24 Hrs. 405 John Atra 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 20 F 222-24-342 6 Director 0 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other treumatic event, the Medical Examiner must be nutiting at 1 Yes 2 □ No Director Sussex Eliware Georgetown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or of Homes. 19947 18100 i Inited States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐Yes 2☐No 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Black 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Delaware State Employee la marked other than Elementary/Secondary (0-12) College (1-4or 5+) erk 1244 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 Is marked any injury or care. Williams Beatrice aumon 19a. Informativs Name/Relationship (Type, Prigt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) husband Augustus Mann 18100 Occation City or Town, State 101257 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) May 10, 2004 MIZion reingetou 22. Name and Address of Facility young's 21. Signature Funeral Service Licenses once. Delaware North Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) LINONIAK HULLER /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2MNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 Nio 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

2 should be fi and Mental H

After death. s after death completely filled in by the within 24 hours a To the Funeral I To the Hospitel

State Registrar

Certification: To

Medical

1 🗆 Yes

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

2 No

29b. Signature and title of certified

31. Date liled (Month, Day, Year)
MAY 1 0 2004

5 Pending investigation

6 Could not be determined

3□ DOA

28c. Injury at Work?

1 TYes

2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28l. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600

1 N Inpatient

28a. Date of Injury (Month, Day Year)

Registrar's Signature

2 ER/Outpatient

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

28b. Time of

				partment of Health and Mental leartificate of Death	Hygiene Reg. No. 2004 16857					
Г	°Physici		1. Decedent's Name (First, Middle, Last)  James John Milmoe, Sr.	2. Date of Month May	Day 2 Year.					
¥ -	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
÷ ,	Funeral		10285 Windstream Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Columbia    If Under 1 Year   If Under 24 Hrs.   8. Date 0	Howard  of Birth h, Day, Year)  9. Birthplace (State or Foreign Country)					
	Funeral Director		143-20-2004 ★M 2□F 76 Yrs.	Months   Days   Hours   Min.   (Month	10, 1927 Country)					
	ryland thow	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits					
	the Ma 28a-f s	Director	MD Howard Columb	ia 10f. Zip Code	1 ☐ Yes 2 ☐ No					
	23s or	al Di	10285 Windstream Drive	21044	USA					
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23s or 28s-f show fermatic event. The Madical Examiner marks and like a second to the Madical Examiner marks and like a second to the Madical Examiner marks and like a second to the Madical Examiner marks and like a second to the marks and the Madical Examiner marks and the Mad	by Funeral	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: 1946-47	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 № No Specify:	14. Race · American Indian, Black, White, etc.  Specify: White					
21215-0036	vithin 72 hou ne. han "nature e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry U.S. Department of					
2	filed w Hygie other tr ent. In	Φ	5+ Tra	ining Officer  18. Mother's Name (First, Mi	Agriculture  ddle, Maiden Sumame)					
Maryland	ould be Menta narked natic ev	To B	James Christopher Milmoe		cila Mooney					
Ma	nd 2 sh alth and 27 Is n ir treun			ling Address <i>(Street and Number or Rural Route Ni</i> Walnut St., Falls Churc						
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Monta Importent: If item 27 is marked eny injury or other treumatic a once.		20a. Method of Disposition  Disposition  Disposition  Removal from State  20b. Place of Disposition  Commetery, CA  Fort Lin	ematory or other place) More 1/	20c. Location - City or Town, State  Brentwood, MD					
Balti	permit. Departm Importe eny inju			22. Name and Address of Facility Francis	J. Collins Funeral Home Silver Spring, MD 20901					
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirato	ory arrest, Approximate Interval Between Onset and Death					
j.	/Medical Examiner		disease or condition resulting in death)  a. Atherosclerotic  Due to (or as a consequence of):	Cardiovascular Disease	Years					
	ted nsit	Examiner	Sequentially list conditions, in the sequence of the sequence							
,092	death certificate be executed e attending physician and inf for use as the burial-transit	Ical Exar	that initiated events c. Due to (or as a consequence of):							
89	leath certificat attending phy ifor use as th	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy							
P.O. Box	the death or by the atten- ached for us	Physician/Med	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery  Month Day Year  —					
Ś	The law requires that the de ate has been signed by the a bage 2 should be detached (	by	Disheres							
Record		Completed			Was an autopsy available prior to completion of cause of death?  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No					
Vita	ysician; The is certificate hadirector, page	Be	25. Was case referred to medical examiner?  1 Yes 25 No  Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check o						
Division of Vital	ing Ph After th Ineral	ation; To	1 Yes 22 No 1 Inpatient 2 ER/Outpatie  27. Manner of Death 28a. Date of Injury (Month, Day Year)  2 Accident investigation	all 30 DOA 40 Nuising Home 3 14	Residence 6 Other (Specify) ribe how injury occurred					
Divis	spitel or Atten ours after deat terel Director: filled in by the	Sertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Locati City of	on (Street and Number or Rural Route Number, r Town, State)					
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	edical C	29a. Certifier (Check only one)  Check only one)  1 Certifying Physician: To the best of my knowledge, deal of the best of my knowledge, deal of the best of my knowledge, deal	ath occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the ti	the cause(s) and manner as stated. me, date and place, and due to the cause(s)					
	withii To the	Ž	29b. Signature and title of pertifier	29c. License number	29d. Date signed (Month, Day, Year)					
	1011		30. Name and addless of person who completed cause of death (Item 23a) (Type	D51860	May 11, 2004					
	-0:		Jonathan Fish 10700 Charter Drive #2  31. Date filed (Month, Day, Year)  32. Begistrar's Signature							
	Sta Registi		MAY 13 2004	Sparks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene (1) (1) L.

Certificate of Death Reg. No.

			For State Registrar	State of Mary		tificate of			Reg. No.	104	19998		
		ø	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath	Year	3. Time of Death		
	°Physicia /Medic		James Frank Moulton	ı Jr.				May	Day 7	2004	6:25 p <sup>M</sup>		
).	Examin		4a. Facility Name (If not institution, give stre				r Location of Death			nty of Death			
	<u> </u>		3126 Gracefield Ros  5. Social Security Number 6. Sex	Silver If Under 1 Year		8 Date of Bird		tgomer					
	Funeral Director			1 2□ F	yrs. last birthday) 82 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month Da NOV 9,	1921		lace (State or Foreign try) ngton DC		
	/land		10a. State 10b. County 10c. City, Town or Location 10d. I										
	Man a-feh ified	tor	MD Montgomen	ry	Silver	Spring					1 ☐ Yes 2√ No		
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		try?		
	ath w	ral	3126 Gracefield Ro			20904			USA				
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 le marked other then "naturel", or Items 23s or 28a-f ehow eny injury or other traumatic event, it e Modical Examiner must be notified at once.	by Funeral	11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever Armed Forces? 1 Tyes 2 XNo If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	ace - America lack, White, e cify: Whi	etc.		
5-0	72 ho natur dical	Completed	15. Decedent's Educa (Specify only highest grade of		16a. Deced	ent's Usual Occup	ation during most of worki	ng		Business/Ind			
2	rithin ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worki				ernment/		
	iled w tygieu ther ti		17. Father's Name (First, Middle, Last)	5+	Phy	s <u>icist</u>	18. Mother's Name	/First Middle			of Defense		
and	d be f antal I ted of	o Be	James Frank Moulto	on Sr				Ritter					
Maryland	shoul nd Me mark	ပ	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	and Number or Rura			n, State, Zip	Code)		
	alth a		Jeanne B. Moulton/W	Lfe	3126	Gracefie	1d Rd. #2	12, Sil	lver Sp	ring,	MD 20904		
Jre,	as 1 a of Hez		20a. Method of Disposition	1	Ob. Place of Dispos	sition (Name of natory or other place	(a) May	ate 11	20c. Location	1 - City or To	wn, State		
Ĕ	Page ment and with the control of th		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren 1 ☐ Donation 5 ☑ Other (Specify) E1		Gate of F	terv	200	4			ng, MD		
Baltimore,	permit Depart Import eny inj		21. Signature of Funeral Service Licensee	rento	22	Name and Addre	ss of Facility Fra sity Blvd						
r	7		23a. Part. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between										
-	Pnysician	1	Immediate Cause (Final disease or condition Pneumonia										
	/Medical Examiner		resulting in death)	Due to (or as a co									
3	Examine.	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):								
	nsit	nine	Cause (Disease of hijury	540 (0, 40 4 00	11304801130 01).								
	tificate be executed ig physician and as the burial-transit	Exal	that initiated events c. resulting in death) Last	Due to (or as a co	nsequence of):								
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	ntifical ng phy as th	Medi	IE ECHALC	-177									
.O. Box	that the death cer ed by the attendin detached for use	by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \triangle Yes \) 2 \( \triangle No \) 9 \( \triangle Unknown \)			23d. Date of delivery Month Day Year							
ls, P	s that ned b e deta	y P	Part II. Other significant conditions contri		t resulting in the un	iderlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to the	e cause of death?		
rd	w requires that been signed to should be det		Parkinson's Disea	se				101	res 2. ZNo	3 🗌 Proba	ably 4 □Unknown		
Record	e la has	Completed						24a. Was autop perfo 1 Yes	rmed?	prior to com death?	osy findings available appletion of cause of		
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uc.	ding f	Certification:		28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 ∐ No	28d. Describe h	now injury occi	ırred			
Division	Attending or death. sctor: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury -	At home, farm, stre			28f. Location (S	Street and Nun	nber or Rural	Route Number,		
Ö	al or / after I Dire d in b	erti	4 Homicide	28e. Place of Injury - building, etc. (S	pecify)	,		City or Tox	vn, State)				
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my r: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the tirestigation, in my o	ne, date and place, a pinion, death occurr	and due to the	cause(s) and r date and place	nanner as sta a, and due to	ated. the cause(s)		
	To the within 2.	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sign				
	1		doven hith	manana	a, MD	059	524		May	,10,	2004		
	>		30. Name and address of person who com Loveen Puthumana, M			· ·	Silver Sp	orina. N	MD 209	004			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature								
	Registr	ar	MAY 11 200	Bener	2	spark.	1						

			For Stata Ragistrar	State	of Marylan		artment o				giene	2004	168	50
		3	Decedent's Name (First, Middle	e, Last)						2. Date of Dea			3. Time of De	eath
П	°Physici		Maria Nicolasa	Melendez						Month	Day	Year		
3	/Medic		4a. Facility Name (If not institution				4b City Tow	m, or Location		May	8	2004 County of Deal	5:00	p^
<i>f</i>	Examin	er					Wheat		OI DOGUII					
<i>b</i> ,			Randolph Hills  5. Social Security Number	Nursing 6. Sex	Home 7. Age (In yrs.	last hirthday)	If Under 1 Ye		24 Hrs.   9	I. Date of Birtl	2	ontgome		
D	Funeral Director		218-56-7844	1 ☐ M 2 ☐ ¥F		73 Yrs.		ays Hours	Min.	(Month, Day	r, Year)	D. Diff	thplace (State or F	oreign
-	Director		Usual Residence of Decedent						10	ec 6,	1930	ruei	rto Rico	-
	fand ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City I	Limits
	f sh	ō	MD Mont	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	C.	11	7						1 ☐ Yes 2	No
	the 28a-	ec	10e. Street and Number	gomery	<u> </u>	ilver S	10f. Zip Cod	de			10a Citiza	en of What Co	untay?	
	with road	Ö	13842 Tabiona	Drive				0906					Juliu y I	
	be filed within 72 hours after death with the Maryland lal Hygiene id other than "naturel", or Hems 23s or 28s-f show event, I've Medical Esain, et med Le medified at	Funeral Director			cedent Ever in U	C 12			ining (Canai	ty Van as Na	USA	4. Race - Ame	door ladion	
	lterr	Ĕ	11. Marital Status	Armed F		.5.	Was Decedent If Yes, specify (	Cuban, Mexical	n, Puerto Ri	can, etc.)	1.	Black, Whit		
36	rs aff	by F	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes C	ive		1 Yes 2□	No Specify:	Puert	o Rica	n s	Specify: Wh	ite	
21215-0036	hou hou	be		t's Education	Dates.	16a Dagg	dent's Usual Oc							
<u>5</u>	"na "na	Completed	(Specify only highe	st grade completed	)	(Give	kind of work do DO NOT use re	one during mos	st of working	,	TOD. Kind	d of Business/	industry	
7	withi ane. than	m	Elementary/Secondary (0-12)	College	(1-4or 5+)						Food	l Servi	ce	
77	Hygie Hygie Ither Int, I		17. Father's Name (First, Middle,	I ast)		Laret	eria Wo		er's Name (	First, Middle,				
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3	nould I Me nark	2							ia Ay					-
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other treumatic event, I was page.		19a. Informant's Name/Relations  Jose Melendez-A		Unahand		ng Address (Str							
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altimore,	2 = 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		20a. Method of Disposition  1 Durial 2 Cremation	3 Removal from	State Gaf	emetery crer	sition (Name of matory or other leaven	place)	May 1		20c. Loca	ation - City or	Town, State	
Ξ	Pag ant:		* 4 ☐ Donation 5 ☐ Other (S		Gat	Cemete	rv	-	= 2004	4	Silv	er Spr	ing, MD	
ā	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee	1	22	2. Name and Ad	ddress of Facili	ty Franc	cis J.	Coli	ins Fu	neral Ho	me
m	2 Q E 2 9		Tru S.	Scerk	0	50	00 Unive	ersity	Blvd.	W. S13	lver	Spring	. MD 209	01
			23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  500 University Blvd. W. Silver Spring. MD 2  Approximation of the mode of dying, such as cardiac or respiratory arrest, interval B											
Ü	Physician		Immediate Cause (Final Find Stage Alghostmon's Discoses										Onset and Dea	
	/Medical		disease or condition resulting in death)	a	o (or as a conseq		ler S D	isease					years	
N.	Examiner													
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	uted  ansit	Examiner										1		
	exector and and all-tra	Exa	resulting in death) Last	C. Due to	(or as a conseq	uence of):								
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89	ficate g phy is the	e e		U										
ŏ	eath certific attending p	W/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregna	incy					23	d. Date of deli	iverv	
m	atter for t	ciar	in the past 12 months?		birth 2 Feta		Ectopic pregna Other (specify				20	Month	Day Yea	ır
o.	at the de by the a tached	Physician/M	1 □ Yes 2 🔯 No 9 □ Unknown	9□ Unk		Out. 5_	2 Other (Specify	//						
<u>a.</u>	igned by be deta		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying cause	a given in Part I		23e. Did to	bacco use	e contribute to	the cause of deat	th?
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	vician: The certificate harector, page	Co								perform	11807 2xE No	death?	2 🗆 No	
Vita	Physician: Th r this certificate ral director, pay	Be	25. Was case referred to medica examiner?							Check only on				
7	Physi this c	2	1 ☐ Yes 2 No		Inpatient 2		t 3 DOA	Other: 4 ₩ Nu	ursing Home	5 🗌 Reside	ence 6 [	Other (Spec	cify)	
_	ding P h. After 1 funera	on:	27. Manner of Death 1 □Natural 5 □ Pendir	28a. Date (Mo.	of Injury nth, Day Year)	28b. Time of Injury	28c. li	njury at Work?	286	d. Describe ho	ow injury	occurred		
9	Attandi death. ctor: A y the fu	ati	2 Accident investi	gation			M 1	1 Yes 2	No					
Division of	il or Attanding after death. I Director: Afte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Plac	e of Injury - At he ding, etc. (Specify	ome, farm, str	eet, factory, offi	ice	28f	Location (St City or Town		Number or Ru	ral Route Number,	:
	ital o	Cel		L. L										
	losp hou una sly fil	edical	29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physicien: To th Exeminer: On the	e best of my kno	wledge, death	occurred at the	e time, date an	nd place, and	d due to the ca	ause(s) ar	nd manner as	stated.	
	To the Hospitel within 24 hours a To the Funerel C	edi	one)	and ma	nner stated.									
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	Σ	29b. Signature and title of certifie		/	, =	29c. Lic	ense number		2	9d. Date :	signed (Month	, Day, Year)	
•			KIKIK	restra	un ,	20.0	D09	9834			May	10. 20	04	
	10		30. Name and address of person				Print)							
			Barry Rosenbaum		ragut Av	re. Ker	sington	n, MD 2	0895					
	Sta		31. Date filed (Month, Day, Year)		Registrar's Signa	ture /	Spork	21						
	Registr	ar	MAY 11	2004	The same	~	March							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - State Registrar	State of Ma	•		te of Deat	th	Reg.	No. 200	+ 16860	
	Physici /Medic		1. Decedent's Name (First, Middle, La Lloyd William	Noble					ate of Death	2004 Yeer	3. Time of Death	
7	Examir									4c. County of De	ath	
			Harford Memorial				re de Gr			Harford		
	Funeral Director		346-76-0707	ex 7. Age	(In yrs. last birth	Months Months		der 24 Hrs. 8. D. Min. 09/	ate of Birth Jones Bay Y	9. B	rthplace (State or Foreign auntry) 110mia	
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits	
	r 28a-f show	tor	California Sonoma Santa Rosa								1 ☑ Yes 2 ☐ No	
	r 288	Directo	10e. Street and Number			10f. Zip	p Code		10g.	Citizen of What C	ountry?	
	death with the Maryland ms 23a or 28a-f show		626 Lombard Ave.	•			95409			USA		
336	or Ite	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  IV If Yes, Give Year or Dates:		13. Was Decer If Yes, spe 1 \( \subseteq Yes		Origin? (Specify Y can, Puerto Rican ify:	es or No- , etc.)	14. Race - Am Black, Wh		
Maryland 21215-0036	'2 hours natural', ical Ex		15. Decedent's Ed	ducation	16a. (	Decedent's Usua	al Occupation		168	o. Kind of Business		
215	thin 7	npie	(Specify only highest gra Elementary/Secondary (0-12) 12	College (1-4or 5	+) !		ork done during m ise retired)	nost of working				
21	e filed withi al Hygiene. other than vent, the M	Completed			P	aramedi				ledical		
and		Be	17. Father's Name (First, Middle, Last)				18. Mo	other's Name <i>(Firs.</i> Patr		den Sumame) Hefli	0	
Z Z	2 should be and Mental Is marked o	2	Lloyd Noble  19a. Informant's Name/Relationship (	Tune Print)	106	Mailing Addraga	Ctroot and Num					
Ma	d 2 s Ith an 27 Is r traur		Catherine A. Barna	•				Santa R		ity or Town, State,	Zip Code)	
	tem 2		20a. Method of Disposition	uu (WIIC)		Disposition (Nar., crematory or o		Date	-	Location - City o	Town, State	
Ë	Page: ent o nt: If ry or		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification )		1	erris &		5/20/20	04 We	st Chest	or DA	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra 20028.		R.A. Ferris & Co. 5/20/2004 West Chester, PA  21. Signature of Funeral Service Licensee  Tarring—Cargo Funeral Home, P.A.  Aberdeen, Maryland 21001–3399									
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death									
7			disease or condition resulting in death)  a. Panceatic arcinoma.  Due to (or as a consequence of):									
	Examiner		Sequentially list conditions	b								
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consuquence of	)e						
	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Due to for as a	consequence of	١.						
68760,	tificate be executed g physician and as the burial-transit			Due to (or as a	consequence of	,.						
587	tificate ig phys as the	Medicai		. d								
Box (	ires that the death certi signed by the attending d be detached for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)					23d. Date of o Month		livery Day Year	
o.	the d by the	λsi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		0 <u>0</u> 0 (10)						
<u>α</u>	s that the ned by th e detache	Y P	Part II. Other significant conditions o	ontributing to death bu	t not resulting in t	he underlying c	ause given in Par	rt I. 2:	3e. Did tobaco	co use contribute to	the cause of death?	
Records,	w requires been signi should be	ed b							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
သို့	2 0 10	Completed						24	ta. Was an	24b. Were a	utopsy findings available	
Ä	The law ate has page 2:	E O							autopsy performed ☐ Yes 2	2 death?	completion of cause of 2 ☐ No	
/ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					ice of Death (Che				
Division of Vital	ding Physician: h. After this certific funeral director,	2	1 ☐ Yes 2 No		t 2 ER/Outp					6 □Other (Spe	cify)	
'n	tter ther	inol.	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir Inj	ury	8c. Injury at Work?		escribe how in	njury occurred		
isic	death death stor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be		nr. At home form	M atreat factor	1 □ Yes 2 [		nation (Strant	and Number of D	ural Route Number,	
Di	after Direction by	ertif	4 Homicide determined	building, etc.	(Specify)	i, street, lactory	, onice	Zai. Lo	ty or Town, St	are)	arai Houte Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	(Check only 2 Medical Exam	ysician: To the best o	examination and/	death occurred or investigation,	at the time, date a , in my opinion, de	and place, and du eath occurred at ti	e to the cause ne time, date a	a(s) and manner as and place, and due	s stated. to the cause(s)	
	o the ithin ( o the mple	Med	one) 29b. Signature and title of cardifier	and manner stat	ea.	290	License number	r	29d I	Date signed (Mont		
	⊬ ≱ ⊢ 8		1 total			1	>0\$6	\$ 768	/	5/14/	04	
	K	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Muhammad Tokhadar, 281 E. Main St, Rising Sun, MD 21911								7	
	Sta	.0		o khadav 32. Registra				t, Ris	ing S	an, Mi	5 21911	
	Sta Registr			6 2004	0.0.	k Sa	100					

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NOBIE,

Larry L. Newby Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-03038 1- State of Maryland Department of Health and Mental Hygiene State of Maryland Department of Health and Mental Hygiene Michael State of Death Red. No. Red. No. Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Newby 2004 May 5, 0402 /Medical P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**2**M 2□F 214-60-9281 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits treumatic event, the Madical Evartiner must be notified at Director WICOMDOS 1 Yes 2 No 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? ò 7944 Jersey 21201 U.S.A or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ res 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: MGN nc BIACK þ 3 ☐ Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Kesturant COOK 12 th 91Ad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Newb 4 Lessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 le -S.lisb.14 Neuby Jersey Ld mic 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 10c. Location - City or Town, State Burial 2 Cremation 3 ☐Removal from State 4 Donation □ Other (Specify) 21. Signatur ... Eurieral Service Licensee 22. Name and Address of Facility 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cocaine Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physiclan/Medical usa as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the period of the details Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Hypertensive Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2 No o the Hospitel or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1

Yes 2 □ No 28b. Time of found 3:00p 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending found 5/4/04 investigation 1 ☐ Yes 2 📆 No 2 Accident unknown hours after deat 6 X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7944 Jersey Rd., Salisbury, MD þ within 24 hours aft To the Funaral Di completely filled in residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 5, 2004 hi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LING LI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20,2004 GRACE BRIGGS PULLEN MAY /Medical 6:25A.M. 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WALDORF HEALTHCARE WALDORF CHARLES H Under 24 Hrs. 8. Date of Birth Hours Min. NOV • 7 1911 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 9. Birthplace (State or Foreign N • Country) 1□ M 2X F 579-12-2605 Months Days 92 Yrs. Director Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits MARYLAND CHARLES Directo WALDORF 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4140 OLD WASHINGTON ROAD 20602 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No 2 Specify: 3 XWidowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) STATISCAL CLERK U.S.GOVT. filed is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental JOHN THOMAS BRIGGS DAISY EULALIA SPRINKLE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any Injury or other tra once. ELIZABETH COOPER-DAUGHTER Health 5400 WASHINGTON AVE. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of h 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 5-25-04 ALEXANDRIA, VA. 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events bunal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician the Due to (or as a consequence of) resulting in death) Last use as Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be detached 23b. Did tobecco use contribute to the ceuse of deeth? signed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No ğ Completed been s 24a. Wes an autopsy 24b. Were autopsy findings performed' completion of cause of death? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a edical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) are MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12000 old line Center, Suite 202, Waldorf, MD 20002 Timothu tace M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

			1 - State of Maryland / De	partment of Health and Nertificate of Death	∕lental Hygie Reg	ene 2004	16863
П	III. D		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
п	Physicia /Medic		Bernice M. Peel		May 9, 2		3 05pm M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	•
1. 4			Forest Glen Skilled Nursing Center	Silver Spring		Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Coun	
	Director	ļ	345 14 7283 80 Yrs		July 9,19	923   I11iı	nois
	land ow		10a. State 10b. County 10c. City, Town o	Location		1	Od. Inside City Limits
	Mary -f sh fied	tor	Maryland Montgomery Silver	Spring			1 ☐ Yes 2 反 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	itry?
	h with		1909 Plyers Mill Road	20902	US	Α	
	deat	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
9	after or Ite	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	010.
8	filed within 72 hours after death with the Maryland Hygiene. Vither than "natural", or ttems 23s or 28a-f show ant, the Medical Examinat must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:			Wh	ite
Ϋ́	"nat	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation iive kind of work done during most of work e. DO NOT use retired)	king 16	b. Kind of Business/Ind	dustry
12	withli ene. then	ршс	Elementary/Secondary (0-12) College (1-4or 5+)	les Associate	м	ens Clothi	no
d 2	filled Hygi ther snt, I		17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma.		ng
Maryland 21215-0036	ld be ental ked c	To Be	Thomas Ziolkowski	Rose I	rene Kuzn	icki	
N.	shou mar	-	19a. Informant's Name/Relationship (Type, Print) 19b. M	ailing Address (Street and Number or Rui	ral Route Number, C	city or Town, State, Zip	Code)
Ž	alth a		Jeanine L. Young/Daughter 1909	Plyers Mill Road, S	ilver Spr	ing,Maryla	nd 20902
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 2 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition		Date 20	c. Location - City or To	wn, State
Ĕ	Pagenent Hand			le Historical Cem. 20	004 S:	nellville.	Georgia
alt	armit. apartr aports ny inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $Fra$	ncis J. C	ollins Fun	eral Home
_	207 2 2			500 University Blvd			MD 20901
п			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line	enter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onget and Death
	Physician	1	Immediate Cause (Final disease or condition	War accellent			10 ocen
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		7	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
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8760,	cate be executed physician and the burial-transit	dlcal E	d				
68	ifficat g phy as th	ledi					
Вох	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of delive	*
	0 0	sicle	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)		Month	Day Year
P.0	that the deed by the detached	Physiclan/Me	9 Onknown	and the fact of the Death	22a Did tabas	cco use contribute to the	an enune of death?
ŝ	requires that the een signed by th hould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Fait i.		2 □ No 3 □ Prob	, /
000	w requires to been signer should be a	eted	1 Williamy / Wire &		-		
Records,	12 E	Completed			24a. Was an autopsy performe	prior to cor	psy findings available apletion of cause of
	Th ate pag				1□ Yes 2x	No 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:	Other :	the Check only one)	- 500	
of	Physical distribution	1: To	1	e of 28c. Injury at	28d. Describe how	e 6 Other (Specify injury occurred	/)
on	th: After funer	tlor	1 H atural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura	l Route Number,
ā	s after s after al Dire	Certification:	4 Homicide building, etc. (Specify)		Only or Town, 2	nater	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only (Ch				
	To the H within 24 To the Fi complete	Medical	one) and manner stated.				
	To Too	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	vay, rear)
•	10		VILIAN DECKEN	000017		110/04	
	7		30. Name and address of person who completed cause of death (Item 23a) (Ty		Y 1	1 00000	
	-	10	Myron L. Lenkin, M.D., 2309 Shoref		, Maryland	1 20902	
	Sta Registi		MAY 12 2004 Server &	sparks			

			1 - For State Registrar	State of M	aryland	d / Depa	artmen rtificat	t of H	ealth	and N	Mental Hy	/gien	6.00	4 1686
71	Physic	ian	Decedent's Name (First, Middle,					_			2. Date of D Month		ay Year	3. Time of Death
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	Examir	ner	4a. Fecility Name (If not institution,	give street and number) FMaru La					Location			4	c. County of Dee	th
	Funeral			1		ast birthday)	If Under			r 24 Hrs.	8 Date of B	irth	0.73	
	Director		214-33-5832 Usuel Residence of Decedent	1 X M 2 □ F	7		Months		Hours	Min.	8. Date of B (Month, D NOV • 7	, 19	27 RUS	thplace (State or Foreign ountry) S.I.A
	how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Sa-f	Director	MARYLAND MONTGO	MERY	ROC	KVILLI	E							1X Yes 2 □ No
	or 24	Dire	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What C	ountry?
	e 23e		256 CONGRESSIONA				208						.S.A.	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow eny injury or other treumatic event, the Madical Exchibit mail by nutified at once.	/ Funeral	11. Marital Status 1 ☐ Never Married 2 🔯 Marrie	12. Was Decedent Armed Forces?  1  Yes 2 X		1	Was Deced f Yes, spec 1 ☐ Yes :				ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit	
8	urel'.	d by	3 Widowed 4 Divorced	Year or Dates:					Specify	•			Specify: WH	IITE
21215-0036	n 72	Completed	15. Decedent's (Specify only highest			16a. Deced	lent's Usua kind of wor DO NOT us	k done d	urina mos	st of work	ing	16b. i	Kind of Business	/Industry
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Maryland	ould by Menta	To E	BORIS		LMUTO				SOPH				LOBA	
Mai	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship										or Town, State,	
ē,	1 an Heali Iem 2		BETYA LERMAN/WIF:  20a. Method of Disposition	<u> </u>	20b. Pla						#103,		KVILLE, ocation - City or	MD 20352
ÖE	ages ont of		1 🔀 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State		ice of Dispo metery, cren EAN ME								
Baltimore,	arith Poortar	. 4	21. Signature of Funeral Service Lie		JUDE	22	Name and	d Address	of Facilit	b.			EY, MARY	
ä	Departition Depart	. 14	> amanda	Ludewa		EI 10	WARD 191 RC	SAGE CKVI	LL FU	NERA PIKE	L DIREC	CTIO	N, INC. E. MARYI	AND 20852
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused ity one cause on each tir	the death.	Do not ente	or the mode	of dying	, such as	cardiac o	or respiratory a	rrest,		Approximate tnterval Between
}-1	Physician		Immediate Cause (Finat disease or condition	a. poste	rior	circ	u (a	hor	1 15	che	mia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):								raays
	-0.0	-	Sequentially list conditions, if any, leading to immediate	b. Nyper Due to (or as	-ter	5104								
	ted insit	min	cause. Enter Underlying Cause (Disease or injury	diabe		ince or).								
o`	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as		ince of):	-					· · · ·		
8760,	The faw requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit			d										
39 )	artifica ing ph B as ti	Med	tF FEMALE:											
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	leath 3 🗌	Ectopic pre						23d. Date of deli	
o.	that the de sed by the a detached f	Physician/Medical	1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of dea	th 5 □	Other (spe	city)					Month	Day Year
۳.	res that igned by be deta		Part tt. Dther significant conditions	contributing to death bu	ut not result	ing in the un	derlying ca	use giver	in Part I.		23e. Did to	obacco i	use contribute to	the cause of death?
<u>rds</u>	w requires been sign should be	Δ		nal insu									□No 3□Pro	
ပ္ ပ	aw re	piet					1			_	24a. Was	an	24b. Were au	opsy findings available
		Completed									autop perfo 1 Yes	med? 2 No	death?	copsy findings available completion of cause of
ita Ta	r this certific ral director.	Be (	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o		1 10163	2 140
0	5 5 7	5	1 Yes 2 No	Hospital: 1 X Inpatier		NOutpatient			4 🔲 Nui	rsing Hom	ne 5 ☐ Resid	lence	6 □Other (Spec	ify)
5	After fune	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury		c. injury a Work?			8d. Describe h	ow injur	y occurred	
Division	Attending ir death. ector: After by the fune	ficat	2 Accident investigat 3 Suicide 6 Could not	be con Diagnatia	inv - At hom	e farm etro	M et factors	1.15	s 2 🗆 N		Of Logation /	`*	440-1	
	rs after rs after al Dire	Certification	4 Homicide determine	building, etc	. (Specify)	o, iaiii, sii e	et, factory,	onica		-	City or Tow	n, State	a Number or Hui )	al Route Number,
	o the nospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying F	Physicien: To the best of eminer: On the basis of and manner state	O A all III I a LI U	edge, death n and/or inve	occurred at estigation, i	t the time n my opir	, date and nion, deat	d place, a h occurre	nd due to the d d at the time, d	ause(s)	and manner as place, and due	stated. to the cause(s)
Ì	Tot		29b. Signature and title of certifier	Al da	n	eviolog	y 29c.	License r	number			29d. Dat	e signed (Month	Day, Year)
1	5		Mullinger	3 alleron	a a Bran	reside	. 1	210	580	5		MI	24 11,	2004
			30. Name and address of pe so	5 11			rint)			ח			44.00	
	C.C.	0	Shawhna (31. Date filed (Month, Day, Year)	- Patters 32. Flyistra			5. Gr	reen	e D	F. 15	paltim	ore	MD 2	1201
	Stat Registra	· ·		2004	, o orginatur	19	Spa	ets.	/					

hysici		1. Decedent's Name (First, Middle, Last)		Ce	rtificate of	Dealli	2. Date of Death Month	Day Year	3. Time of Death
/Medic		Margaret Dorothy	y Pettee				May 5, 2	004	11:00 A <sup>M</sup>
xamir		4a. Facility Name (If not institution, give				or Location of Deat	h	4c. County of Dea	
		Villa Rosa Nursing			Mitchell			Prince G	
neral ector		210-38-3132	7. Age (In yrs. 97	last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min.		(ear) 9. Bir 1906 Qui	thplace (State or Foreign buntry) ncy, MA
<b>*</b>		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ly, Town or L	ocation				10d. Inside City Limits
a pa	ō	MD Prince Ge	eorge Mi	tchell	willo				1 ☐ Yes 2 🔯 No
then Tatural, or tems 23a of 28a-1 snow the Medical Examiner must be notified at	Director	10e. Street and Number	111	COHOLL	10f. Zip Code		10	g. Citizen of What Co	ountry?
28 0		3800 Lottsford V:	ista Road		20721			U.S.A.	
ms z	Funerai	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	. Was Decedent of h	Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame	
2		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		1 ☐ Yes 2 ☒ No		to Fican, etc.)	Specify: White	
2	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10 165 2E NO	эрвспу.		Зреспу: ***	
nata Heat	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	edent's Usual Occuj e <i>kind of work done</i> DO NOT use retire	pation during most of wo	rking 1	6b. Kind of Business	Industry
Wen.	npl m	Elementary/Secondary (0-12)	College (1-4or 5+)			d)	i		
	S	17. Father's Name (First, Middle, Last)	4	Home	maker	18 Mother's Na	me (First, Middle, M	wn Home	
event,	Be	Frederick W.A. Sh	1111 to				aude Spla:	•	
nark natic	2	19a, Informant's Name/Relationship (Ty		10b Mail	ling Address /Street			City or Town, State, I	Zin Code)
traun		1	ghter				016 Paris		-1p Code)
ther the		20a. Method of Disposition	<u> </u>	7 11	osition (Name of amatory or other pla		100000	Dc. Location - City or	Town, State
٥٤٤		1 ☐ Burial 2 🛱 Cremation 3 ☐ F	removal from State	cemetery, cre • Comf					
		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>			OF L 22. Name and Addre			Alexandria	
important: If item 27 is marked other eny injury or other traumatic event, once.		21. Signature of Pureral Service Licens						wler's Sor	
-		23a. Part1. Enter the disease, or complete	ications that caused the day					ington, Do	Approximate
		shock, or heart failure. List only of	ne cause on each line.					.,	Interval Between Onset and Death
ician dical	1	disease or condition resulting in death)	<sub>a.</sub> Sepsis						48 Hours
niner		1	Due to (or as a consec		[mfootdom				/.O II
	7	Sequentially list conditions,	b. Urinary T		Intection				48 Hours
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
al-tra	Xai	that initiated events resulting in death) Last	c.  Due to (or as a consec	quence of):					
Siciar buri	100		d						
g physician and as the burial-transit	edical		d					1	
nding physiciar use as the buri		IF FEMALE: 23b. Was decedent pregnant	d		□Estania orașana			23d. Date of de	ivery
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gned by the attending phy se detached for use as th	by Physiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown ntributing to death but not res	al death 31 death 51	Other (specify)		23e. Did toba 1 □ Yes	Month	Day Year
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ifier this certificate has been signed by the attending phy uneral director, page 2 should be detached for use as th	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1   Yes   2 \overline{S}No    9   Unknown  Part II. Other significent conditions co    Senile Deme  25. Was case referred to medical examiner?  1   Yes   2 \overline{S}No    27. Manner of Death    1 \overline{S}Natural   5   Pending investigation   3   Suicide   4   Homicide   6   Could not be determined	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown  Intributing to death but not res  I limpatient 2  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Specia	al death 3 ideath 5 i	Other (specify) _ underlying cause gr  ent 3 DOA Other of 28c. Inju Wo M 1 _ street, factory, office	26. Place of De her: 4 ∰ Nursing H ry at kr? ] Yes 2 □ No	1  Yes  24a. Was an autopsy perform  1  Yes  24h (Check only one)  10	Month  2XNo 3 Pr  24b. Were au prior to death? No 1 Yes  ce 6 Other (Speringury occurred	Day Year  the cause of death?  obably 4 Unknown  utopsy findings available completion of cause of 2 No  cify)
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ifier this certificate has been signed by the attending phy uneral director, page 2 should be detached for use as th	Certification: To Be Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown  Intributing to death but not res  I linpatient 2  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - Athouiding, etc. (Special interes) on the basis of examina and manner stated.	al death 3 in death 3 in death 5	Other (specify) underlying cause gr  ent 3 □ DOA Other of 28c. Inju Wo M 1 □ street, factory, office ath occurred at the trinvestigation, in my 29c. Licen D22	26. Place of De her: 4 Mursing Herk? I Yes 2 No	24a. Was an autopsy perform  1	Month  2XNo 3 Pr  24b. Were at prior to death? No 1 Yes  No 6 Other (Speringury occurred  set and Number or Ristate)  se(s) and manner as e and place, and due  d. Date signed (Montay 7, 2004	Day Year  the cause of death?  tobably 4 Unknown  topsy findings available completion of cause of 2 No  cify)  ural Route Number,  stated. to the cause(s)  h. Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MAY 11, 1:14 P M PLESH 2004 HARRIET **ESTELLE** /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 □ F Yrs 82 JUNE 16, 160-16-2328 1921 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Mudical Exercition must be notified at 1 Yes 2 No Directo MD MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 923 PAULSBORO DRIVE 20850 UNITED STATES or items 23a death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specity: ģ 3 Widowed 4 □ Divorced WHITE natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) othar than Elementary/Secondary (0-12) College (1-4or 5+) **AGENT** INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If I lem 27 is marked oth y injury or other traumatic eventes. Be ABRAHAM ROTHMAN **EVELYN** FLINKMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5837 TUDOR LANE, ROCKVILLE, MD SUSAN KATZ SMITH, DAUGHTER 20852 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burja 2 Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Speofly) METROPOLITAN CREMATORY 5/13/2004 ALEXANDRIA, VIRGINIA 21. Signature 1 Funeral Service Licenses DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD tarey 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) **Physician** Intracranial Ken /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-transit Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic or gnancy in the past 12 months? Month Day Year 5 Other (specify) be detached o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes Z√Q\No of Vital or Attending Physicien: ector, 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1800 Division 1 DNatural 5 Pending Hell down Stairs death. investigation 2 Accident ior 3 ☐ Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 5637 TV DR LN ROCKVIILE MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOMC Diract à 4 Homicide within 24 hours a to the cause(s) and manner as stated.

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only onel 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier nmearsmarkuell 1700 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELISSA MARKWELL, M.D., 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 14 2004 YAM Registrar

				For State of Maryl	land / i	Departmer <i>Certifica</i> :	nt of He te of D	ealth and N Death		giene <sub>2</sub>	004	16867
				Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
		Physici /Medio		Lois Odessa Jolley Parker					04	29	04	20:00 PM
	7	Examin	er	4a. Facility Name (If not institution, give street and number)	M G	4b. City	Town, or . ک	Location of Death AUSSUN	1		lunty of Death	1100
		Funeral		5. Social Security Number 6. Sex 7. Age (In )		Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	place (State or Foreign ntry)
		Director		220-32-2373 1□ M 2 ☐ F 7  Usual Residence of Decedent	1	Yrs.	5.0,0		Jan 19	, 1933	Mar	yland
		yland			City, Tov	vn or Location						10d. Inside City Limits
		th with the Marylan 23s or 28s-f show	Director		aurel							1 ☐ Yes 2/1 No
		with the sor 20	Dire	10e. Street and Number 4564 John Cooper Road			9956				n of What Cou USA	ntry?
		death with the Maryland ims 23a or 28a-f show r rount be notified at	nerai	11 Marital Status 12. Was Decedent Ever	in U.S.			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No		Race - Ameri	
	92	or Ite	y Fur	1 Never Married 2 Married 1 Yes, Give		1 ☐ Yes		Specify:	Hican, etc.)		Black, White,	
	Ş	hours turai',	Completed by Funeral	3 Wildowed 4 Divorced Year or Dates:	16a	. Decedent's Usu	al Occupa	tion			of Business/Ir	
	215	hin 72 3. 10 "na Medic	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		(Give kind of we life. DO NOT L	ork done d	uring most of work	ing	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,
	21	ygiene ygiene her the	Соп	12th	1:	aborer		18. Mother's Nam	a (Eirak kkindolla	Dom e		
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, it is Marical Execution to the inclined and once.	o Be	17. Father's Name (First, Middle, Last)  Elijah S.	Joll	ev		Charlo		G.	·	Hopkins
	ary	should and Me smark umatic	2	19a. Informant's Name/Relationship (Type, Print)			s (Street a	nd Number or Aur				
	Z	and 2 ealth a n 27 is		Louis Parker/husband				oer Rd -				9956
	Jore	iges 1 of H it itsu or oth		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemete	of Disposition (Na ery, crematory or Nebo UM	other place	<sub>3</sub> )	Date 5/2004		ion - City or To hia. De	own, State elaware
	Ħ	artmer artmer ortant injury		. 4 □ Donation 5 □ Other (Specify) 21. Six at ire of Funeral Pervice Licensee								sbury, MD
	B	Departing Department of the policy of the po		+ Alrea U. Ja	lle	JOLL	EY M	EMORIAI	CHAP	EL		21801
				23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause an each line.	death. Do	not enter the mo	de of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Qnset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Mys.	condial	P	Asmilia	lui			hours
		Examiner		Due to (or as a con	nsequence	of): Proteins	1	CANEN -			13	Vars
0		7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence	of):		y CM y Car			t	
9		ecutec and -transi	Examiner	Cause (Disease or injury that initiated events c	acaduanca acaduanca	of):						
02	8760,	icate be executed physician and s the burial-transit	dicai E	Due to (or as a con	1354061100	01).						
à	9	tificate ig phys as the	ledic	d								
80-00	Вох	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 mg/m/s?  23c. If yes, outcome of prediction in the past 12 mg/m/s?  □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	Fetal deatl					23d	. Date of delive	ery Day Year
00	0.	he dea the al	ysici	1  Yes 2  No	of death	5 Other (s	pecify)					
6	٥.	w requires that the deben signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death but not	t resulting	in the underlying	cause give	n in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
Joyc	ords	v require. been sig should b	led b	Peripheral Vareadar Dise	CAS L	- Anex	, c Bri	ain Injury	1 🗆	Yes 2 🗆 K	lo 3 ☐ Prot	pably 4 □Unknown
UNE	Record	lawri nasbe e 2 sh	Completed	Strake, Hyperlipidemia,	D'ahi	ter Stell.	Fire		24a. Was auto		4b. Were auto prior to co death?	opsy findings available impletion of cause of
7		i <b>ician:</b> The lav certificate has rector, page 2		Renal Failure				/	1 ☐ Yes	2 10 No	1 🗆 Yes	2 No
Parke	Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Ho spital: 1 ☑ Inpatient	2 🗆 ER/O	utpatient 3□ D	OA Othe	26. Place of Deat r: 4 ☐ Nursing Ho			Other (Special	(y)
	n of	ding Phys h. After this funeral di	Di: T	27. Manuar of Death 1 Natural 5 Pending (Month, Day Yea	28b.	Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury o	ccurred	
-015	Division	Attanding r death. ector: After y the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	At home f	M arm street factor		es 2□No	28f Location (	Street and N	lumber or Run	al Route Number,
Y	Div	after after I Direct d in by	Certification:	4 Homicide determined building, etc. (Sp.	pecily)	arrit, Stroot, lactor	y, omce		City or To			,
		Hospital 4 hours a Funeral C	caic	29a. Certifier   1 Certifying Physicien: To the best of my   Check only   2 Medical Examiner: On the basis of examiner								
		the the	Medicai	one) and manner stated.  29b. Signature and title of certifier			c. License		-		igned (Month,	
	,	To To		V/ By VB and	D		D5	5427		24	73	7084
				30 Name and address of person who completed cause of death	,	11	1.	10 -		()	1	
31	2			31. Date filed (Month, Day, Year)  32. Registrar's S		in Heart 1	65M.	Hord St.	cs. 4 S41	he hes	Salithie	y , MD 21804
		Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's S  MAY 0 7 2004	- J	5 Sp	als	/				

	ı	1 - For Stete Registrer	State of M	aryland		rtment tificate			ınd M		Reg. No	711111.	168	68
Physic	ian	Decedent's Name (First, Middle, I Stella	Last) M.			Ree	ce.			2. Date of E Month	Death	y 2004	3. Time of 5:50F	
/Med Exami		4a. Facility Name (If not institution, g	give street and number)					Location o	f Death	May		. County of Death	3.301	
EAGIT		Renaissance Cardens						Spri	_			Prince Ge		
Funera Director		5. Social Security Number 239–30–2044	. Sex 7. Ag	ie (In yrs. lasi 78		If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of E (Month, I Dec. 1,	1925	9. Birthp Cour Nort	lace (State of htry) 1 Caro]	Foreign Lina
land		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	cation						1	0d. Inside Cit	y Limits
a-fehr	ctor	Maryland Anne A	rundel	C	dento	on							1 🗆 Yes	2 <b>X</b> No
a or 28	i Dire	10e. Street and Number 2456 Apple Bloss	som Lane			10f. Zip 0	113				-	izen of What Cour ted State		
(1213-5-0035 within 72 hours after death with the Maryland ene. than "natural; or items 23a or 28a-1 show the Madical Examiner mast be notified at	y Funeral Director	11. Marital Status  1 Never Married 2 Married	If Yes, Give 41		l	Vas Decede Yes, specif	_	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or Nican, etc.)	lo-	14. Race - Americ Black, White,		
215-UU36 thin 72 hours af e. an "natural; or Medical Exert	ted by	3 XWidowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	1	I6a. Deced	ent's Usual	Occupa	ition			16b. K	ind of Business/In-		
ZTZTS ZTZTS d within 72 giene. er then "n"	Completed	(Specify only highest (Specify only highest (Specify only highest (O-12)	College (1-4or	5+)	(Give life. 2	kind of work OO NOT use	done di retired)	uring most	of workin			nce Georg rd of Edi		
yiand Z ould be filed Mental Hygi tarked other tatic event, I	9	17. Father's Name (First, Middle, La Coy	st)	Stout	:			Verd		(First, Midd	le, Maiden	Sumame) ( Ur	ık)	
Mary id 2 shou th and N 17 is mai	_	19a. Informant's Name/Relationship Gilmer R. Reece			19b. Mailin 2456	g Address ( Apple	Street a	nd Numbe DSSOM	r or Rural Lane	Route Num e Oder	ber, City o	or Town, State, Zip Maryland	Code) 3 21113	3
Baltimore, Marylar permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 is marked any injury or other traumatte a once.		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3  4 🗆 Donation 5 🗔 Other (Spe		cem	etery cren	sition (Name natory or oth	er niace	neter		ate 14/200	0.0	ocation - City or To		rylan
Physician Pe executed Examiner  purial-transit	icai Examiner	21. Signature of Funeral Service Lice  23a. Part1. Enter the disease, or constant failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uncurrying Cause (Disease or injury that intitated events resulting in death) Last	Bagward	c Obsta a consequent	44 Do not ente cructince of):	00 Pot or the mode	wder of dying	Mill g, such as d	Rd.	Belt	svill	ome, P.A.	and 20 Approximate Interval Betw Onset and D	reen
that the death certificate ted by the attending physical detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	ath 3	Ectopic pred Other (spec						23d. Date of delive Month	*	ear
S S S S	þ	Part II. Other significant conditions	s contributing to death b	ut not resultir	ng in the un	iderlying cau	use give	n in Part I.			tobacco u	use contribute to th	e cause of de	
I KeC The law ate has b	Completed									per 1 Tyes	opsy formed? 20 No	death?	osy findings a npletion of ca 2 \(\textstyle \text{No}\)	vailable use of
V9	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2∏ER	/Outpatient	3 DOA	Othe			(Check only		6 □Other (Specify	·)	
VISION OT Attending Phys or death. ector: After this by the funeral di	ition; T	27. Manner of Death  1 \( \bar{\Delta}\) Natural 5 \( \bar{\Delta}\) Pending  2 \( \bar{\Delta}\) Accident investigat	28a. Date of Inju (Month, Da	iry 28	b. Time of Injury		c. Injury Work	at ? 'es 2 🗆 N	2	Bd. Describe			,	
- F = -	Certification;	3 Suicide 6 Could not determine		ury - At home c. (Specify)	, farm, stre	eet, factory,	office		2		(Street an own, State	d Number or Rura )	Route Numb	er,
To the Hospital or within 24 hours af To the Funeral completely filled in	dical C	29a. Certifier	Physician: To the best aminer: On the basis o and manner st	f examination	dge, death and/or inv	occurred at estigation, in	the time	e, date and inion, deat	l place, ai h occurre	nd due to the	e cause(s) , date and	and manner as st I place, and due to	ated. the cause(s)	
To the To the comple	Me	29b. Signature and title of certifier			D		License 9524	number			29d. Dat May	11, 2004	Day, Year)	
10		30. Name and address of person wh	o completed cause of d	leath (Item 23	Ba) (Type, f		61.7			.191	one-			
" S	tate	Ioveen Puthumana 31. Date filed (Mönth, Day, Year)	32 Registr	ar's Signature	4	d Rd.			sprir	ng, Ma	rylar	nd 20904		
Regis	1.5	MAY 12 20	104 Suc	,	frat j	and a const	Mary Mary							

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	Physici /Medi		Luis			uiz_					May C	)8, <sup>2</sup> 2(	004 Year	1615P.	М
	Examir	ier		fnot institution, give ove Adven		ital		4b. City, To Rocks		ation of Dea	th		County of Dea Montgom		
2000	Funeral Director		5. Social Security N 212-61-3	3846	7. Age	e (In yrs. last	birthday) Yrs.	If Under 1 Months C		Under 24 Hrs ours Min		int.	0.0	thplace (State or I ountry) Caragua	-o <i>reig</i> n L
,	ith the Maryland or 28a-f show	ctor	Usual Residence of 10a. State MD	10b. County  Montgom	ery	10c. City, T Ge1	own or Lor				-			10d. Inside City	
	3a or 28	I Dire	10e. Street and Nur 20313	mber Beaconfi	eld Terr	ace		10f. Zip Co	ode 0874				zen of What C		
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural", or Items 23a or 28a-f ehow minjoury goother traumatic event. If a Medical Event with interesting to fulfied and once.	ed by Funeral Director	11. Marital Status 1	ed 2□ Married	12. Was Decedent E Armed Forces? 1 Yes 2 XN tf Yes, Give Year or Dates:	40	1	⊠Yes 2□ Ni	No S	oecify: aguan	Specify Yes or N no Rican, etc.)	lo-	14. Race - Am Black, Whi	encan Indian, te, etc. Vhite	
Maryland 21215-0036	d within 72 giene, ir than "na	Completed	(Spec Elementary/Seco.	ify only highest grad	College (1-4or 5	+)		ent's Usual C kind of work o OO NOT use i dent	done durin retired)	g most of wo	orking		chool	, industry	
and	d be file	Be	17. Father's Name	(First, Middle, Last) erto Rui	7						me (First, Middl Salaza		Sumame)		
	and 2 should be filed within eath and Mental Hygiene. n 27 le marked other than "ler traumatic event, the Max	To	19a. Informant's Na	ame/Relationship (Ty lazar/Mo	pe, Print)	1			treet and i	Number or A	ural Route Num	ber, City or		zip Cod <b>2</b> 087 town <b>,</b> MD	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 eny injury ocother tr. once.			osition Cremation 3 F 5 Other (Specify)	emoval from State	ceme	tery, crem	sition (Name patory or othe lega C	r place)	erio	Date 5/15/0	<sup>20c</sup> Loc Ch	cation - City or inande caragu	Town, State ega, la	
Balt	permit. Departr Importe eny inju		21. Signature Fu	neral Service Lice	ild.		PH 92	TETP	des Ri	fNALD oia B	I FUNE	RAL :	SERVIC Sprir	CE,P.A. ng,Md209	910
	Iticate be executed  Medical Examiner Is the burial-transit	l Examiner	23a. Part1. Enter the shock, or hear the shock or hear the shock or condition resulting in death)  Sequentially list confrant, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death)	n ditions, imediate riving injury	Cardiac  Due to (or as a	e arrhy a consequence ous con a consequence	thmi ce of): conar ce of):	a		ch as cardia	c or respiratory	arrest,		Approximate Interval Betwe Onset and De:	
P.O. Box 68760,	*= C3 et	hysician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 9 □ Unknown	months?	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal dea		Ectopic pregr Other (specif				2	3d. Date of de	ivery Day Yea	àr
	luires that I	by P	Part II. Other signifi	icant conditions cor	tributing to death bu	ut not resultin	g in the un	derlying caus	e given in	Part I.		tobacco us		the cause of deal	
I Recol	: The law requir cate has been s page 2 should	Completed									24a. Was auto peri 1 Yes	s an opsy ormed? 2 \( \sum No	24b. Were au prior to death? 1/07 Yes	itopsy findings ava completion of caus	ulable se of
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certiwithin 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	tion; To Be	25. Was case referrexaminer? 1  Yes 2  2  27. Manner of Death 1  Natural 2  Accident	No H	ospital: 1 Inpatier 28a. Date of Injung (Month, Day	2 62 5	Outpatient  o. Time of tniury		04	□ Nursing I	ath (Check only dome 5 Res 28d. Describe	idence 6		city)	
Divisi	spital or Attendi burs after death. lerel Director: A filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, . (Specify)	farm, stre				28f. Location City or To	(Street and wn, State)	Number or Ru	ıral Route Number	,
	To the Hospital within 24 hours a To the Funerel Completely filled	edical C	Check only one	1☐ Cartifying Phys 2☑ Medical Examin	iclan: To the bast of ner: On the basis of and manner stat	examination	ge, death and/or inve	occurred at the estigation, in a	ne time, di my opinior	the and place n, death occu	a, and dea to the urred at the time,	causa(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	To the within To the Comp	Me	29b. Signature and	inge of certifier or fe	on				cense nun C.M.E				signed <i>(Monti</i> 09, 200		
	i.		TUAK	on log	mpleted cause of de	eath (Item 23a	a) (Type, P	<sup>Print)</sup> 111	Penn	Stree	et, Balt	imore	e, Mary	land 212	01
7.	Sta Registr		31. Date filed (Mont	h, Day, Year) Y 10 200		r's Signature	4	Soa	W						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Dete C Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 10:35 pm /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Carroll horien 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ F Months 218-14-4896 81 Yrs. Director Usuel Residence of Decedent 2 should be filed within 72 hours efter death with the Marylend and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-f show 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Completed by Funeral Director Md. Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1101 Jousting Way 21771 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WWII 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) P1 umber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Frank Rush Mildred Dodson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 sh Depertment of Health and Important: If Item 27 is m any injury or other traum 1101 Jousting Way, Mt. Airy, Maryland Harriet F. Rush / Wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 5/6/04 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 22 Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses Box 5038, Laytonsville, Md. P. 0. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Cardio Vascular Desen Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours effer death.

To the Funeral Director: After this cartificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of ceuse of death? Medical Certification: To Be Compieted 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Yeer) 30641 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Rameth Sabapally 3 400 Erdman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2004 MAY 6 /Medical Rosen Kenneth 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** Peninsula Regional WICOMICO Medical Center If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 X M 2 ☐ F Director 56 December 22,1947 Pennsylvania 153-42-6241 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 23e-f show any injury or other treumatic event, the Medical Examinat must be redifficed at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Funeral Director Greenbackville Virginia Accomack 10g. Citizen of What Country? 10e. Street and Number USA 14. Race - American Indian, 37224 Sail Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1968-1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White 1974 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Service Technician</u> Electric 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rosen Ester William ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45 East Vine Street, Gibbstown, New Jersey 08027 (daughter) Lisa <u>Nastase</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Harleigh Crematory May 13, 2004 Camden, New Jersey

22 Name and Address of Facility
Holloway Funeral Home Professional Association

501 Control Hill Bood Saliebury Maryland 21804 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bicensee Keth f 501 Snow Hill Road, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Musd disease or condition resulting in death) an /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Month Year Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \( \square\) No After this certificate has No 1 Tyes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (CI eck only one) Other: 4 \sum Nursing Home 2 NO 3 DOA 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 5 Residence 6 Other (Specify) Medical Certification; To 28b. Time of Injury 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending 2 🗆 No 1 🗌 Yes death. investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel o within 24 hours at To the Funerel D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Po Box ell , Amin 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 1 1 2004 Registrar

-03.	199		For Stete Registrar		State of M	aryland		artmen tificate			and M	ental Hy	gien Reg. N		16872
	Physici /Medic	al		min Sm	ith							2. Date of De Month May 1	D	ay Ye <i>a</i> r 2004	3. Time of Death $0434~{ m P}^{ m M}$
	Examir Funeral	CI	4a. Facility Name (If not Southbound  5. Social Security Number	I 95 &	Keith Ave	enue	ast birthday)	4b. City, Balt If Under Months	imor	Location of		8. Date of Bi	rth	c. County of Dea	tholace (State or Foreign
	Director		225-50-8929 Usual Residence of Dec 10a. State 10b	)	<b>⊠</b> M 2□F	54 10c. City	Yrs.		Days	Tiodis	- 1	ct. 17		V 2 22 7	y Land  10d. Inside City Limits
	h the Mary r 28a-f she r rotified	Director	10e. Street and Number		illiam	Mana	assas	10f. Zip					10g. C	itizen of What C	1 Tes 2 No
920	hours after death with the Maryland turel', or Items 23a or 28a-f show al Examinat be notified at	by Funeral	8624 Newtor  11. Marital Status  1  Never Married  3  Widowed 4	<b>2</b> ∕∕Married	12. Was Decedent Armed Forces? 12 Yes 2 If Yes, Give Year or Dates:	•				spanic Ori n, Mexican Specify:	gin? (Spe I, Puerto f	cify Yes or No Rican, etc.)		S • A  14. Race - Am. Black, Whi  Specify: Wh	
Maryland 21215-0036	hin 72 a. an "na	Completed	15. (Specify of Elementary/Secondar	Decedent's Ed nly highest gra y (0-12)	ucation de completed) College (1-4or:		16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us ntrac	k done d e retired,	urina most	t of workir	ng		Kind of Business	
aryland	thould but marked	To Be (	17. Father's Name (First William Pa  19a. Informant's Name/	ul Smit			19b. Mailin	ng Address	(Street a	Fran	ices	(First, Middle  Bassis  Route Numb	t	or Town, State,	Zip Code)
	les 1 and 2 s of Health ar of item 27 is or other trau	1 0	Martin Kyle  20a. Method of Dispositi	on	(Son)		12825 lace of Dispo emetery, cren	sition (Nam	ne of			hester		A 23831 Location - City or	Town, State
Baltimore,	permit. Pages Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ 21. Signature ☐ Funers	Other (Specify	)		g Davi	. Name an	d Addres		HOU	ntcast	1e :	ls Churc Funeral	
	Prrysician		23a. Part1. Enter the di shock, or heart fail Immediate Cause (Fina disease or condition resulting in death)	lure. List only	a	ine.	nty	er the mode	e of dying		cardiac or	r respiratory a		e orey,	Approximate Interval Between Onset and Death
,09	Examiner	ical Examiner	Sequentially list condition any, leading to mined cause. Enter Underlying Cause (Disease or injurithat initiated events resulting in death) Last	liate J	b. Due to (or as	а солзеци	iance of).							_	
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Physical and a control of the contro										24a. Was auto perfe 12 Yes	an psy ormed? 2 \( \sqrt{N}	death?	utopsy findings available completion of cause of		
Division of Vita	ol or Attending Physicien: The after death. I Director: After this certificated in by the funeral director, pag	Certification; To Be	Accident		28e. Place of In	y Year)	ER/Outpatien 28b. Time of Injury me, farm, str	M 2	8c. Injury Work 1 🗀 Y	at	rsing Hom	8d. Describe	how inju	6 Other (Speury occurred)  And Number or Riverse	At Scene  Acudent  ural Route Number,  Ave
	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by th	edical	(Check only 2 🔀	Medical Exem	ysician: To the best liner: On the basis of and manner st	of examinati	wledge, death ion and/or inv	vestigation,	in my op	inion, deal	d place, a th occurre	nd due to the	date ar	nd place, and due	e to the cause(s)
•	Tol	Σ	29b. Signature and title	of certifier	eno				.C.M					ate signed (Mont	
	10		30. Name and address of APCIN	Lough	mo				Penn	Stre	æt,	Baltim	ore,	, Maryla	nd 21201
	Sta Registi	- 6	31. Date filed (Month, D	-	32. Registr	ar's Signat		Cons	or or	•					

DHMH 17 Rev 1/2001

ORIGINAL

Discontinue   The Activity   Discontinue			1 - For State Registrar	State of Maryl	•	artment of H		nd Me		ene 1. No. 2 A	0:	100
Compared   Compared	/Medi	cal	1. Decedent's Name (First, Middle, Last)  Claire Gertrude	Smith		4b. City Town or	r Location of			2004		3. film of Coath 0615 P M
Director of Loss Date   10.4 Sales   10.5 County   10.5 Revision   10.5 County   10.5 Revision			University Hospita  5. Social Security Number 6. Se	al 7. Age (In		Baltimor	e If Under 2	4 Hrs.	8. Date of Birth		9. Birthpl	ace (State or Foreign
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23a. Part Lette the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate shock, or heart failure. List only one cause on sent international course (Final International Causer	yland ould be file Mental Hy arked oth atic event	Be	Morris Kaplin				Rose	кпе	pler			
Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate the death of the disease or complications that caused the death.  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a	Baltimore, Mai permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once.		Sharyn Obsatz (Da 20a. Method of Disposition The Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	10600 Db. Place of Dispo cometery, creations	White Oaksition (Name of natory or other place)  d Memoria Name and Address	ak Dri	Lve, Da 05/14 Mou	Rivers: 20 /04 Fa	ide, (continue)  alls Ch	CA 9 City or Too curch	2505 wn, State VA
Due to (or as a consequence of):    Section   Continue	/Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a. Add	P lyn						_ <b>V</b> A	
FFMALE   23c. Ms decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	760, e ba exacuted sician and e burial-transit	cai Examiner	if any, leading to immediate cause. Enter Underlying cause Unsease or injury that initiated events	Due to (or as a cor								
25. Was case referred to medical examiner?    1	.O. Box 68' the death certificat y the attending phy tchad for use as th	nysician/Medi	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1□Live birth 2□ 4□Pregnant at time	Fetal death 3		/					
25. Was case referred to medical examiner?    1	rds, P quires that in signed b uld be deta	ě	Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause grv	ren in Part I.					\.
This plant is the policy of th		Complete						<del></del>	autopsy performs	ed? p	rior to con eath?	npletion of cause of
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29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  May 12, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Perpo Street - Baltimore - Maryland 21201	Division calor attending Parter dath. In Director: After the din by the funera	Sertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Yea	At home, farm, st	M 1 🗆		10 p	esserte of	telect.	or or Rura	Thicker I Pout on Manda
O.C.M.E. May 12, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore, Maryland 21201	the Hospit in 24 hours the Funers pletely fille	edical	(Check only 2 Medical Exami	iner: On the basis of exa	knowledge, deat mination and/or in	vestigation, in my o	pinion, deat	d place, at h occurre	d at the time, dat	e and place, a	nd due to	the cause(s)
111 Penn Street, Baltimore, Maryland 21201	To t To t	W	29b. Signature and title of certifier  Their line M	1 Kg un	2					-		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	12	tate	THERDORF MIK	ing	1	11 Penn S	street	, Ba	ltimore,	Maryla	and 2	1201

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	Maryland	-	artment of He tificate of D			iene <sub>eg. No.</sub> 2	004	16874
	Physici /Medic		Decedent's Name (First, Middle	e, Last) Anna	a Strite	2			2. Date of Dea Month May	Dav	2004	3. Time of Death 11:15 A. M
	Examin		4a. Facility Name (If not institutio 14035 Pennsy1				4b. City, Town, or I Hagerst				ty of Death shing	ton
	Funeral Director		5. Social Security Number 214-34-1146	6. Sex 1 □ M 2 💢 F	7. Age ( <i>In yr</i> s. <i>Ias</i> 79	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 14	1925	Cour	place (State or Foreign ofry) Land
	e Maryland Ba-f show	etor		ington		Town or Lo	town					0d. Inside City Limits 1 ☐ Yes 2 No
	th with th	Funeral Director	14035 Pennsylv	ania Ave.			10f. Zip Code 21742		1	0g. Citizen of		ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, ite Medical Exactinar fund for rediffical and once.	þ	11. Marital Status 1 ☐ Never Married 2 ᠓ Mar 3 ☐ Widowed 4 ☐ Divorced	ned Armed Fo 1 ☐ Yes If Yes, Giv	2 ∰ No e		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 ☒ No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Wh	
Maryland 21215-0036	d within 72 ho piene. r than "natur the Medical	Completed		nt's Education st grade completed) College (1		(Give life.	dent's Usual Occupat kind of work done du DO NOT use retired) Homemaker	ion tring most of work	king	16b. Kind of I	Business/Ind Home	dustry
and 2	id be filed ental Hyg ked other c event,	Be	17. Father's Name (First, Middle, Norman	Last) Diller					e (First, Middle, Martin	Maiden Suma	me)	
Mary	id 2 shoulith and Mills mark	ပ္	19a. Informant's Name/Relations I. Landis Stri		i		ng Address (Street ar 5 Pennsylv					
Baltimore,	Pages 1 ar nent of Hea ant: If item ; ury or other		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (5		State Mill	er s	sition (Name of natory or other place Mennonite metery			20c. Location Leiter		
Balt	permit. Departr Import. any inj		21. Signature of Funeral Service  H. Martin	Licensee Zermen	·~ 5~	Z Z 4	Name and Address immerman 2 5 S. Carl:	of Facility And Son : Ls1e St.	Funeral Greenca	Home I stle,	nc. Pa. 1	7225
2,0928	Medical Examiner bhysician and street be executed with the properties of the purish transit is the purish transit.	dical Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	YPERKI or as a conseque	nce of):	O.FO	DISEASE				Interval Between Onset and Death
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Δ.	puires that t n signed by nd be deta	by	Part II. Other significant conditi	ons contributing to de	ath but not result	ing in the u	nderlying cause giver	in Part I.	23e. Did tol	4		ne cause of death?
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Division	al or Atte s after de: il Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 206. Flace	of Injury - At hom ng, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (St City or Town		ber or Rura	l Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (		ng Physician: To the Exeminer: On the ba and man	sis of examinatio							
	To the within to the complex c	ž	29b. Signature and tifle of certific				29c. License			9d. Date sign		,
,	2		30. Name and address of person	<del></del>	e of death (Item 2	3a) (Type		059055		MHY	18,2	004
	Sta	te		VIE MP	1293 egistrar's Signatur	31 0	AKHILL	AVE, H	AGERTO	IN, M	0 2	1742
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 21, 3:30 A.M MAY 2004 LORETTA ANNA SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EMMITSBURG FREDERICK 510 E. MAIN ST. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1□M 2X F Yrs. FEB.21,1925 79 Director 220-18-0522 FAIRFIELD, PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other freumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director FREDERICK EMMITSBURG, MD. MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 510 E. MAIN ST. 21727 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2🗓 No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 7 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be THELMA SANDERS 2 EARL ADAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 E. MAIN ST., EDWARD J. SMITH, JR./HUSBAND EMMITSBURG, MD. 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State NEW ST. JOSEPH'S 5/24/2004 EMMITSBURG, MD. 21727 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between nset and Death Dseudo Myxong Pnysician resulting in death) /Medical 4 8915 Examiner Colon Caucer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of) physician The law requires that the death certificate be P.O. Box 6876 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day ō Month Year 5 Dther (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 X No 1 Yes of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Dther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) Medical Certification; To 1 Yes 2X No 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division 1 X Natural 5 Pending 1 Yes 2 No investigation death. 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MJ-013738-8 Bluglely un MAY 21, 2004 (4, MA) 524 S. WASHINGTON ST. GETTYSBURG, PA. 17325 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

		aryland / Department of Certificate of	Health and Mental Hy	
Physician /Medical	WILFORD FRAI	NKLIN SAUL	2. Date of De Month MAY	12, 2004 12:38 A
Examiner Funeral Director	5814 63rd AVE.  5. Social Security Number 6. Sex 7. Ag 153-26-6573 X M 2 F			PRINCE GEORGES  th ay, Year) 9,1935  9. Birthplace (State or Foreign Country) NEW JERSEY
with the Maryland or 28e-f show be redilised at	Usual Residence of Decedent  10a. State  10b. County  MD • PRINCE GEORGES  10e. Street and Number	10c. City, Town or Location  RIVER  10f. Zip Code		10d. Inside City Limit 1 XYes 2 □ N 10g. Citizen of What Country?
urs after death val', or Items 23s	5814 63rd AVE.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 XDivorced  12. Was Decedent Armed Forces?  1 Yes, Give Year or Dates:	No 1958— 1 □ Yes 2 X N 1961		Specify: WHITE
be filed within 72 hours lat Hygiene. d other than "nature event, the Medical Be Completed		life. DO NOT use reti	e during most of working ed)	N.I.H.  , Maiden Surname)
d 2 should be flied the and Mental Hy 27 is marked oth traumatic event	WILFORD ALEXANDER S  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	MARY E at and Number or Rural Route Numb	LIZA MONROE er, City or Town, State, Zip Code)
ss 1 and 2 of Health a litem 27 is r other train	ROBIN JUSTICE/DAUGHTER  20a. Method of Disposition	270 DRESSER  20b. Place of Disposition (Name of cemetery, crematory or other p.	AVE., PRINCE FRE	DERICK, MD.20678  20c. Location - City or Town, State
permit. Pages Department of Important: If It any injury or o	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Vicensee	CHAMBERS CREMATO	·	RIVERDALE, MD.
Attended to be executed by sician and buriat-fransit he buriat-fransit he buriat-fransit he frankliner lical Examiner	Sequentially list conditions, if any, trading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as	a consequence of):  a consequence of):  a consequence of):		Onset and Death
es that the death certificate gned by the attending physbe detached for use as the by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3 Ectopic pregnan	су	23d Date of delivery  Month Day Year
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ician: The law requir certificate has been si rector, page 2 should			24a. Was auto peric 1 ☐ Yes	
this aldii	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatie	ry 28b. Time of 28c. Injury W	26. Place of Death (Check only of ther: 4 Nursing Home 5 X Residury at 28d. Describe lock?  Yes 2 No	
p at in it			City or To	
To the Hospitel .within 24 hours a .within 24 hours a .completely filled .completely filled	29a. Certifier 1	ated.	opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
441	30. Name and address of person who completed cause of d	lu)	D0060050	MAY 12, 2004
State Registrar	4 0 0001	.D. 1221 MERC	ANTILE LA., LARGO	), MD. 20774

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 8 2004 1:40  $P^{M}$ Shreeve Elsie Starks /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 1 F 115-10-7447 91 10, 1912 New York Director Dec. Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location teme 23e or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23e or 28a-f ehow injury or other traumatic event, the Middical Examiner must be notified at once. 1 XYes 2 No Gaithersburg Directo Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Russell Avenue #305 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritat Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( Winnie Guenther Charles D. Starks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Shreeve III / Son 1602 Ridout Road Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date May 10, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donayion 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Pert1. Soler the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Erebiologie disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of): Due to Examiner or Attending Physician: The law requires that the death certificate be executed MUSTO use as the burial-tran and that initiated events resulting in death) Last Due to (offas a consequence of): Box 68760, ding physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy lor Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No O 9 Unknown 9 Unknown þ ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 X No 1 Yes 2 X No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖳 No Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) determined filled in by 4 Homicide Hospital within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0313 2004 20 30. Name and address of person who completed cause of deat (Item 23a) (Type, Print) 15215 Shady Grove Road #100 Suhair Abulfarag, M.D. Rockville, Maryland 20850 31. Date filed (Month, Day, Year)

MAY 11 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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	rland ow		Usual Residence of Decedent  10a. State 10b. County	/	10c. City, Town	or Location		/ /		10d. Inside City Limits
	e Man 3a-1 sh	ctor	MARYLAND MONTGO	MERY	(	GAITHERSBUR	l.G			1 □ Yes 2 No
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356	hours after death with the Maryland tural', or Items 23a or 28a-1 show al Exeminer must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1	ever in U.S.	13. Was Decedent of No. 11 Yes, specify Cub	an, Mexican, Puerto	pecify Yes or No- Pican, etc.)	14. Race - Ame Black, White	
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8760,	icate be executed physician and s the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a	a consequence of	):				
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Vita	sician: The certificate hi rector, page	Be	25. Was case referred to medical examiner?	Hospital				th (Check only one)		<b>X</b>
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DIVIS	al or Attend s after death il Director: /	Certification:	3 Suicide 6 Could not determined		ry - At home, farr (Specify)	m, street, lactory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
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	. 🗅	Ň	29b. Signature and title of certifier	I Muste	d	29c. Licen:	se number 581//	29d	Date signed (Month	, Day, Year)
	10			completed cause of de	eath (Item 23a) (T			Any 61	eter St.	
	Sta Regist		31. Date liled (Month, Day, Year) MAY 14	32. Registra	ar's Signature	5 Spork	n/			

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21215-0036	be filed within 72 hours after death with the Manylan ital Hygiene. bd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be inditied at	by Funeral I	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 XYes 2 If Yes, Give Year or Dates:	?		f Yes, spec	rity Cubar	Specify:	Puerto	Rican, etc.)		ack, White,	etc.
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≥,	1 and Health iom 27		EDWARD M. SPIER/	SON					OW ST	., E	IYATTSV1	LLE, M	D. 20	781
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any injury or other traumatic.		20a. Method of Disposition  1 ☐ Burial 2X☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specif		CB	ace of Dispo metery, crem	natory or ot	her place	1		ate	20c. Location		
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Vital	Physicien: this certificant	Be	25. Was case referred to medical examiner?	Hospital:			-	Other			(Check only on	1	SSIST	ED LIVING
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Divis	in Dirt	Certification:	3 Suicide 6 Could not by determined	28e. Place of Inju- building, etc	ury - At hon c. (Specify)	ne, farm, stre	et, factory,	office	- Wiji	2	8f. Location (St City or Town	reet and Numb n, State)	per or Rural	Route Number,
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	971		mma	MD				D32	2332			MAY 1	2, 20	04
			30. Name and address of person who		eath (Item 2	23a) (Type, F	Print)							
			SUREH K. GUP				RGIA A	VE.	220,	SIL	VER SPR	ING, MI	. 209	02
4	Star Registra		31. Date filed (Month, Day, Year)  MAY 13 2	32. Registra	ar's Signatu	Je Je	Sport	resta	1					

Physicia / Medic: Examine Program | Physicia / Medic: Examine | Physicia | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Physician | Phy

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any in ury or other traumatic event, Ite Mardical Exp. ultrer inside the multiple at once.

DOROTHY STASULL;

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

By 23 MCD. Pre C. Ogh Kee, C. M. Phene. (A) Prevention of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law required that he death certificate be executed with 124 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		rint in Black Indelible Ink. Ensure		
	1 For State of M	Maryland / Department of Health and	Mental Hygiene 2001, 1500	0
	Registrar AMEND#10bper INF5/14/04, E	MW,Mcco Certificate of Death	2. Date of Death 3. Time of Death	U
ian	Decedent's Name (First, Middle, Last)		Month Day Year	A
ical	Dorothy R. Stasulli  4a. Fecility Name (If not institution, give street and number	er) 4b. City, Town, or Location of Dec		
ner				
	CIVISTA MEDICAL CENTE  5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) If Under 1 Year If Under 24 Hi	CHARLES  S. Date of Birth  9. Birthplace (State or Foreign	ın
	577-05-7880	87 Yrs. Months Days Hours Mi	n. (Month, Day, Year) Country) Oct. 2, 1916 Washington, D	C
	Usual Residence of Decedent			
3	10a. State 10b. County Charles	10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 ⊠ No	
Director	Maryland Prince Coorge's	Brandywine		
	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
Funeral	4812 Blueberry Drive	20613  Int Ever in U.S. 13. Was Decedent of Hispanic Origin?	USA (Specify Yes or No- 14, Race - American Indian.	
Į.	11. Marital Status  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐	if Yes, specify Cuban, Méxican, Pue	Black, White, etc.	
þ	If Yes, Give  3 ⊠ Widowed 4 □ Divorced Year or Date:	1 ☐ Yes 2 ☒ No Specify:	Specify: White	
Completed	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry	
ple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	(Give kind of work done during most of w life. DO NOT use retired)	Orking	
Co	12	Keypunch Operator	Federal Government	
Be	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle, Maiden Surname)	
P	Eugene Lynch		to Callaghan	
	19a. Informant's Name/Relationship (Type, Print)		Rural Route Number, City or Town, State, Zip Code)	
	Dominick C. Stasulli/ S  20a. Method of Disposition	Son 4812 Blueberry Driv	ve, Brandywine, MD 20613  Date 20c. Location - City or Town, State	
	1   Burial 2 □ Cremation 3 □ Removal from Sta	comptent promotent of other place!	lay 8,	
	* 4 □ Donation 5 □ Other (Specify)  21. Signature # Fuheral Service Licensee	Cemetery	2004   Silver Spring, Maryla	nd
	I believe to the	Francis J. Collins	Funeral Home Inc.	0.1
	23a. Part1. Enter the disease, or complications that caus	sed the death. Do not enter the mode of dying, such as cardi	zd. W., Silver Spring, MD 2090 ac or respiratory arrest, Approximate	U.I
	shock, or heart failure. List only one cause on each			
	disease or condition resulting in death)	e Brunchtbunk-rut	- COCC 1 STONE CONTAINED EW F	-
	Durio.	RA-17-11-11	ir years)	
je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	as a consequence of):	1000	
Examiner	that initiated events	KENSUNIZM.	1 years	
	resulting in death) East Due to (or a	as a consequence of):	`	
Physician/Medical	d			
/Me	IF FEMALE: 23c. If yes, outcome	me of pregnancy		_
ian	in the past 12 months?	n 2 ☐ Fetal death 3 ☐ Ectopic pregnancy t at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year	
ysk	1 ☐ Yes 2 🖟 No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown			
by Pł	Part II. Other significant conditions contributing to death	h but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	
De De			1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown	1
plet			24a. Was an 24b. Were autopsy findings available prior to completion of cause of	9
Completed			autopsy prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No	
Be	25. Was case referred to medical examiner?	26. Place of D	eath (Check only one)	_
10	1 ☐ Yes 25 No Hospital: Inpa		Home 5 ☐ Residence 6 ☐ Other (Specify)	
on:	27. Manner of Death 1 ★Natural 5 Pending (Month, &		28d. Describe how injury occurred	
catl	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	204 Location (Street and Musels and Control	Ц
Certification:	4 Homicide determined 286. Place of building,	Injury - At home, farm, street, factory, office, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier TR Certifying Physician: To the be	est of my knowledge, death occurred at the time, date and pla	ce, and due to the cause(s) and manner as stated	
Medical	(Check only 2 Medical Exeminer: On the basis and manner	s of examination and/or investigation, in my opinion, death oc	curred at the time, date and place, and due to the cause(s)	
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
	Land Ande	D-20629	5/7/04	
	30. Name and address of person who completed cause of			
	GEORGE H WATHEN MD 11	345 PEMBROOKE SQ. SUITI	E 103 WALDORF, MD 20602	
ate	31. Date filed (Month, Day, Year) 32. Regi	istrar's Signature & Sports		
trar	IVIAT # 1 ZUU4 /	Last properties		

Regis

			For	State of M	arylan	-				lental Hy	giene 200	4 16881
			For State Registrar			Ce	rtificate	of Dea	ith	2. Date of Dea	leg. No.	
	Physicia	an	1. Decedent's Name (First, Middle, La							Month	Day Yes	3. Time of Death
	/Medic		Blayne Edward S  4a. Facility Name (If not institution, gi	Shunk re street and number)			4b. City, To	wn, or Locat	ion of Death	05	4c. County of D	1.001
	Examin	er	SACRED HEAD	1 1	HAL	_	Cun	nber	Land			GANY
	Funeral		5. Social Security Number 6.		e (In yrs. I	ast birthday,	If Under 1 Y		nder 24 Hrs.	8. Date of Birtl (Month, Day	y, Year) 9.1	Birthplace (State or Foreign Country)
D,	Director		192-12-3866	11-1 M 2UF	80	Yrs.		,	ľ	Nov. 15	1923 Pe	ennsylvania
	land ow		Usuel Residence of Decedent  10a. State 10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
	Mary a-f sh	tor	Maryland Garret	:t	Gr	antsvi	lle					1 ☐ Yes 2 💆 No
	or 28s	Director	10e. Street and Number		<del></del>		10f. Zip Co	ebde			10g. Citizen of What	Country?
	ath w	ral	215 Twin Churches				<u> </u>	215			USA	
	itams	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent Armed Forces? 1. Yes 2		S. 13.	Was Deceden If Yes, specify	t of Hispanio Cuban, Me	c Origin? (Spe xican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
936	urs afi	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1☐ Yes 2🏋	No Spe	cify:		Specify:	White
2-0	d within 72 hours after death with the Maryland liene. I then "natural", or liems 23e or 28e-f show The Medical Evanti et inust be notified at	eted	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Usual C	ccupation	most of worki	na	16b. Kind of Busine	
21	C * 68	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work of DO NOT use i	retired)		9	Auto	
22	filed within Hygiene. other than rant, the M		12. Father's Name (First, Middle, Las	1)		Mecha	HILC	18. N	lother's Name	(First Middle	Maiden Sumame)	
Maryland 21215-0036	D d a b	o Be	Edward Shunk	7						Poleman	maioon obmane,	
ary	iges 1 and 2 should nt of Health and Men if item 27 is marke or other traumetic	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ng Address (S				r, City or Town, State	e, Zip Code)
	1 and 2 Health a am 27 is		Grace Shunk/Wife			215	win Ch	urche	s Road	Grants	sville, MI	21536
ore	of Hea of Hea if itam		20a. Method of Disposition 1   Burial 2 □ Cremation 3 [	Removal from State	20b. P	lace of Dispendence of the lac	osition (Name i matory or othe	of r place)	ľ	ate	20c. Location - City	or Town, State
Ë	. Pages tment of I tant: If its jury or o	174	'4 ☐ Donation 5 ☐ Other (Spec	(fy)	Trir		emetery	_	May 6,		Grantsvi	lle, MD
Baltimore,	permit. Pages Department of Important; If i any injury or once.		21. Signature of Funeral Service Lice	nsee						s, P.A.		
	402 4 4		23a, Part I. Filter the disease, or cor	nolications that cause	the death						Maryland	21536 Approximate
ı	Disconinter		23a. Part1. Enfor the disease, or conshock, or hear failure. List only immediate Cause (Final				- 1				301,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as			= 100	<i>1</i> 2				12marts
L	Examiner	Ì	O Taraffalls for an addition	b								
	D 4≡	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):						
	be executed ician and burial-transit	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	2.0000000	ionoo of):						
760,	ite be executed ysician and ne burial-transit	cal E	4	Due to (or as	a consequ	aerice or).						
687	# × 6	ed		d								
Вох	death certificat e attending phy d for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			∃Ectopic pregr	22224			23d. Date of	delivery
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			☐ Other (special				Month	Day Year
P.0	that the de led by the a detached f	Phys	9 Unknown						=:-	an Distri		
	eg De	by	Part II. Other significant conditions  CALC NOMA	CONTRIBUTING TO GOATH E		atting in the t	inderlying caus	e given in P	anı.	236. Dia to		e to the cause of death?  Probably 4 □Unknown
Records,	w requir been si should	Completed	Pala Ann		\~~' (						•	
Rec	e la has je 2	mp	HEND HUE	100 m	2001	2				24a, Was a autop: perfor	sy prior med? death	
Vital	icien: Th certificate ector, pag	e Co	25. Was case referred to medical					26.5	Place of Death	1 Yes	2 No 1 Y	es 2 No
	ys dir	0	examiner? 1 🗆 Yes 2 🕱 No	Hospital:	ent 2	ER/Outpatie	nt 3 DOA	Othor			ence 6 Other (S	pecify)
n of		T :uc	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o	of 28c.	Injury at Work?			ow injury occurred	
Sio	Attending r death. ector: Afterby the fune	ertification:	2 Accident investigation	20			М	1 Yes				
Division	A di	T,	4 Homicide determined		ury - At ho c. (Specify	me, farm, st /)	reet, factory, of	fice	1	28f. Location (S City or Tow		Rural Route Number,
_	rie fte	(I)		L						and due to the c	ause(s) and manner	
	rie fte	O	29a. Certifier 1 Certifying P	hysician: To the best	of my know	wledge, deal	h occurred at t	he time, dat	e and place, a			as stated.
	rie fte	O	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis o and manner st	f examinat	wiedge, deal	th occurred at to exestigation, in	he time, dat my opinion,	death occurr	ed at the time, o	ate and place, and o	as stated. lue to the cause(s)
	To tha Hospital or within 24 hours after To tha Funarel Director completely filled in I	Medical Cer	(Check only 2 Medical Exa	miner: On the basis of	f examinat	wledge, deal tion and/or in	ivestigation, in	he time, dat my opinion, cense numb	death occurr	ed at the time, o	ate and place, and o	lue to the cause(s)
<b>)</b>	To tha Hospital or within 24 hours after To tha Funarel Director completely filled in I	edical C	(Check only 2 Medical Exa	miner: On the basis of and manner st	f examinat	wiedge, dea lion and/or ir	ivestigation, in	my opinion,	death occurre	ed at the time, o	ate and place, and c	lue to the cause(s)
0.	To tha Hospital or within 24 hours after To tha Funarel Director completely filled in I	edical C	(Check only 2 Medical Exergine)  29b. Signature and title of certifier  30. Name and address of erson who	miner: On the basis of and manner st	f examinat	wiedge, dea lion and/or in	29c. Li	my opinion, icense numb	death occurre	ed at the time, o	ate and place, and c	lue to the cause(s)
0-	To the Hospital or within 24 hours after to the Funarel Direction occupies tilled in	Medical C	(Check only 2 ☐ Medical Exercise)  29b. Signature and title of Certifier	miner: On the basis of and manner st	f examinated.	i 23a) (Type	29c. Li	my opinion, icense numb	death occurre	ed at the time, o	ate and place, and c	lue to the cause(s)
0-	To tha Hospital or within 24 hours after To tha Funarel Director completely filled in I	Medical C	(Check only 2 Medical Exercise)  29b. Signature and title of certifier  20b. Name and address of erson who	miner: On the basis of and manner st	f examinated.	i 23a) (Type	29c. Li	my opinion, icense numb	death occurre	ed at the time, o	ate and place, and c	lue to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16882 State of Maryland / Department of Health and Mental Hygiene 200For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JAMES E. STURGESS 2115 MAG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/2/1935 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months XXM 2□F 69 215-36-5391 WASHINGTON, D.C Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f show DELAWARE SUSSEX MILLSBORO 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19966 30090 LEWIS ROAD U.S.A. Items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. XYes 2 □ No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 52-55 WHITE "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumetic event, the Medical 16b. Kind of Business/Industry 15 Decedent's Education (\$pecify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. ENGRAVING & PRINTING ENGINEER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental MAE B. SMITH JAMES E. STURGESS SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Importent: If item 27 is any injury or other treusonce. 30090 LEWIS ROAD, MILLSBORO, DE 19966 NORMA S. STURGESS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State

Other (Specify) DELAWARE VETERANS CEM. 5/11/04 MILLSBORO, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Walson WATSON FUNERAL HOME, MILLSBORO, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia **Physician** Phochs Intar disease or condition resulting in death) /Medical **Examiner** Colonolou Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Preumonio Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes Diabetes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 Inpatient 0 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 2

5391

35

151

625

Registrar MAY 1 1 2004

100

East

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Correll

& sporks

Doo 60715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 16883 State of Maryland / Department of Health and Mental Hygiene? 🛭 🖺 👢 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 May 11, 8:59A M Daniel John Swann, Sr. 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death La Plata Charles Civista Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | July 11, 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1 M 2 F ,1929 74 Maryland 216-24-6128 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 XNo Charles Faulkner 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9987 Bowling Road 20632 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 🏋 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Trash Collection Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edith Raymond Walter Swann Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Swann/Wife P.O. Box 72 Faulkner, MD 20632 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State St. Ignatius Cem. 5/15/04 PortTobacco, MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licens AREHART ECHOLS FUNERAL HOME, P.A. Ehu Lyang BOX 567 LA PLATA MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ventucu disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

Director

27 is marked other than "natural", or items 23a or 28a-f show treumatic avent, the Medical Exameter must be nutified at

e filed within al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: If Item 27 is marked othe any injury or other treumstic event size.

Swarn, Sp

Darriel J.

**Funeral Director** 

by

Completed

Be

/Medical

10a. State

MD

Examine been signed by the attending physicien and should be detached for use as the burial-transit Physician/Medical þ Completed page 2 s has After this Certification: after death.

The law requires that the death certificate be executed

To the Hospitel or Attending Physician:

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 EN/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 1 Natural 2 Accident 5 Pending

investigation 6 Could not be determined 3 🗌 Suicide 4 | Homicide

28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

29c. License number

D-45737

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an

autopsy performed?

1 Yes € No

1 Yes 2 No 3 Probably

4₀⁄⊒Unknown

24b. Were autopsy findings available prior to completion of cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5/11/04

State Registrar

31. Date filed (Month, Day, Year) MAY 14 4

Gurusamy MD 3328 Old Washington Road Waldorf, MD 20602 egistrar's Signature

B38

within 24 hours at To the Funerel D completely filled i

29a, Certifier

29b. Signature and title of certifier

Nirmaladevi

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** May 2004 5:09 AM 6 Wilma Tosh Jean /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville | ROCKVILLE | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 26, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 X F 64 1940 Illinois 481-50-8223 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? United States 20874 13495 Demetrias Way 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) NGA 4 Cartographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marjorie Lindburg Henry Dunkle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5054 Kenerson Drive Fairfax, Virginia 22032 John Tosh / Son May 7, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State `4 □Donation 5 □Other (Specify) Metropolitan Crematory Alexandria, Virginia 2004 21. Signature of Juneral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial insarction Immediate Cause (Final disease or condition acute **Physician** minutes resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Hinkhown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 1 Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | TER/Outpatient 3 | DOA 1 Yes 2 A Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center D MILLI elourah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	Physici /Medio Examir	cal	Decedent's Name (First     BERNICE     4a. Fecility Name (If not in	EVEL	YN WIN	nber)		4b. City,	Town, or	Location of	of Death	2. Date of De Month MAY	08 <sup>Pay</sup>	2004 County of Dea	6	: 20 PM
	Funeral	lei	GARRETT  5. Social Security Number  235-48-54	COUNT	Y MEM'	L HOS		If Under	OAK	If Under	)	8. Date of Bi (Month, D 1 - 25 -	G db	ARRET 9. Bir	Γ	tate or Foreign
	Director	tor	Usual Residence of Dece 10a. State 10b.		N	10c. Cit	y, Town or Lo	ecation		1		1-25-	1,913	KEI	10d. Insid	JSE, Mi de City Limits Yes 2∑No
	h with the 23a or 28e-	ai Direc	10e. Street and Number RT. 1, B					10f. Zip	Code 2671	6			-	zen of What Co	ountry?	
.0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or flems 23a or 28e-f show int, the Medical Exemple or ust be multified at	Compieted by Funeral Director	11. Marital Status  1 Never Married  Widowed 4		12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? Ž∰No e		1 🗆 Yes	2[XN0	Specify:	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)		14. Race - Ame Black, Whit Specify: WH]	te, etc. LTE	an,
Maryland 21215-0036	be filed within 72 hatal Hygiene. Id other than "naturevent, If e Modical		(Specify on Elementary/Secondary	(0-12)	College (1	-4or 5+)	(Give	kind of wo	rk done d se retired	uring most		ng (First, Middle		OWN HO		
rylanc	Mental Mental arked c	To Be	WILLIAM	CALV		TIN	10h Maili	a Address	,	ADAH	BL	ANCH	BACH		Tin Code)	
	es 1 and 2 s of Health an f item 27 is r other trau		19a. Informant's Name/F SHIRLEY 20a. Method of Disposition 1 XBuriat 2 ☐ Cre	n mation 3 🗆	Removal from S	20b. F	RT.	1, I	3OX	68 A	URO	RA W	V 2	6705 cation - City or D HOUS	Tourn Ctor	te MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Juneral	Service Licen	see ha		H.22	I NKL	d Addres	nera	L H	OME,	INC.		, r	1D
760,	Physician // Medical Examiner pue prijarijarijarijarijarijarijarijarijarija	ical Examiner	shock, or heart failt Immediate Cause (Final disease or condition resulting in death)  Saquantial, list condition if any, leading to immediate. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	re. List only	a. Due to (c	ich line.	uence of):	tings.				ular			Approx Interva Onseta	Batween and Death TON TH
.O. Box 68	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 Yes 2 No 9 Unknown			rth 2 ☐ Fete ant at time of d	Ideath 3	Ectopic pr					2	23d. Date of del Month	ivery Day	Year
Records, P.	w requires that been signed by should be deta	þ	Part II. Other significant		teny o	1		nderlying c	ause give	n in Part I.		23e. Did		se contribute to		of death?
al Reco		Completed	Or Wassers for the									1 Yes	psy ormed? 2 No	death?		ngs available of cause of
of Vital	Physicien: This certificate ral director, p	To Be	25. Was case referred to examiner?  1 Yes 2 No  27. Manner of Death	le le			ER/Outpatien	_		r: 4 🗆 Nui	sing Hor		dence 6	Other (Spec	city)	
Division of	ding h. After fune	27. Manper of Death   Natural   Solicide   Accident   Solicide   Accident   Homicide   Solicide   Accident   Solicide   Accident   Solicide   Accident   Solicide   Solicide   Accident   Solicide   S								ıral Route l	Number,					
	Hospital 4 hours Funerel ely filled	edical Ce	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exen	ysicien: To the liner: On the ba and mann	sis of examina	wledge, death	occurred restigation,	at the tim in my op	e, date and inion, deat	place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cau	se(s)
)	To the within 2 To the complet	Med	29b. Signature and title of	certifier	- 0 t	//	. 1	290	License	number	Inse	(7)		signed (Mont)	h. Day, Yea	ar)
	9		30. Name and address of Murquest	person who o	completed cause iSer M.I	of death (Item	23a) (Type,	Print)	Jusy	·Oa	klur	id ma				
	Sta Registi		31. Date filed (Month, Da	y, Year) AY 2 6	2004 <b>32.</b> Re	egistrar's Signa	iture	Gosel	سي الم							

			1 - For State Registrar	State of M	aryland /		nent of H cate of I		nd Menta		ene . No. 2 (	004	16886
	°Physici /Medic	_	1. Decedent's Name (First, Middle, Mary Kathryn W	eitzel					Ma Ma	te of Death onth y	Day 10	Year 2004	3. Time of Death 7:50a <sup>M</sup>
	Examin Funeral	ier	4a. Facility Name (If not institution, 21030 Miracle D  5. Social Security Number	rive	ge (In yrs. last b	irthday) If I	Gaither Under 1 Year Inths Days	sburg	Hrs. 8 Dat	te of Birth onth, Day, Y	Moi	ntgome 9. Birthol	ery ace (State or Foreign try)
	Director		213-74-1804  Usual Residence of Decedent  10a. State 10b. County	ILM Z	103	Yrs.				21,			DC  Od. Inside City Limits
	the Maryl 28a-f sho	Director		gomery		hersbu				100	Citizen of	What Coun	1 ☐ Yes 2 ☐ No
	th with	al Di	21030 Miracle	Drive			20882				USA		.,.
9036	4 within 72 hours after death with the Maryland liene. Tthen "naturel", or Items 23a or 28a-f show the Madreal Examiner must be neithed at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces d 1  Yes 2  If Yes, Give Year or Dates:	?		Decedent of Hi s, specify Cuba res 2 2 No	ispanic Origin n, Mexican, P Specify:	n? (Specify Ye Puerto Rican,	etc.)		ce - America ack, White, e ify: Wh1	etc.
21215-0036	c * w	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or	5+)	(Give kind life. DO N	Usual Occupa of work done of IOT use retired	during most of )		16	b. Kind of E	3usiness/Ind	lustry
	al Hyg	o Be Co	10 17. Father's Name (First, Middle, L Edward McNa1		P	ersonr	el Sec	18. Mother's	Name (First,	Middle, Ma			ry Dept.
Maryland	id 2 should lith and 27 is m troum	F	19a. Informant's Name/Relationshi	p (Type, Print)			dress (Street a	and Number o	or Rurai Route	Number, C			
Baltimore,			20a. Method of Disposition  1 ★ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Spi	3 □Removal from State	20b. Place of cemeter Gate	of Disposition ary, cremator of Hea	n (Name of ry or other plac IVen	e) Na	Date ay 13 2004		c. Location	- City or To	
Balti	permit. Pag Depertment Importent: I any injury o		21. Signature of Funeral Service Li	Cole			me and Addres	s of Facility	Franci				eral Home MD 20901
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition	ications that cause ne cause on each I	ine.								Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		rsible a consequence		tive H	eart Fa	allure				l year
8760,	rate be executed physician and the burial-transit	ical	resulting in death) Last	Due to (or as	a consequence	of):							
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Ω.	quires that n signed b uld be deta	by	Part II. Other significant condition	s contributing to death t	out not resulting	in the underh	ying cause give	en in Part !.	23	_	_		e cause of death?
al Records,		Completed				_			_	a. Was an autopsy performed Yes 2	d?	prior to con death?	osy findings available apletion of cause of
Vital	Se Ce	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/O	utnationt 7	□ DOA Cthe		Death (Chec		- C 🗆 O#	has (Canaib	1
ion of	ng tter	-	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury Work			escribe how			,
Division	tel or Attendi s after death. al Director: A ed in by the tu	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of in	jury - At home, f tc. (Specify)	arm, street, f	actory, office		28f. Loc Cit	cation (Stree y or Town, S	et and Num State)	ber or Rural	Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dire completely tilled in b	edical	29a. Certifier 1 Certifying (Check only one) Medical E	Physicien: To the best xaminer: On the basis of and manner st	of examination a	je, death occ nd/or investig	urred at the tim jation, in my op	e, date and p pinion, death o	place, and due occurred at th	to the caus e time, date	e(s) and m and place,	anner as sta and due to	ated. the cause(s)
)	T Withi Comp	M	29b. Signature and title of certifier	Williamburs			29c. License	3392				od (Month, $E$	
	7		30. Name and address of person w					77411	ana MT	2080	6		
l,	Sta Registr		31. Date filed (Month, Day, Year)  MAY 11	32. Pegist	rar's Signature		parks		.ge, fil	, 2000	<u>,                                     </u>		

			For State Registrar	State of Maryland	•	rtment of H		-	giene Reg. No.	211111	16887
	Ģ	ţ.	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medio		ARLINE J	UDITH WILC	COX			Month MAY 5,	2004		10:33P M
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Dea	th	4c.	County of Death	
			MONTGOMERY HOSPICE			ROCKV				MONTGOME	
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. las	t birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min		h y, Year) 19	9. Birthp Coun 945 WASHI	lace (State or Foreign try) NGTON, DC
	and w.		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				1	Od. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	tor	MARYLAND   MONTGOMER	Y	OLNEY						1 ∑Yes 2 □ No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Coun	try?
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5-0036	be filed within 72 hours after death with the Marylar Ital Hyglene. Id other than "natural", or frems 23a or 28a-f show event, the Medical Escaling range to relified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in U.S. Armed Forces?</li> <li>Yes 2 XNo If Yes, Give Year or Dates:</li> </ol>		/as Decedent of H Yes, specify Cuba □ Yes 2X No	ispanic Origin? (9 in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Americ Black, White, Specify: WHI	etc.
2 0	72 ho	eted	15. Decedent's Educa (Specify only highest grade	ition completed)	16a. Deced	ent's Usual Occupa	ation during most of wo	nrkina	16b. Kir	nd of Business/Inc	lustry
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2	be filed tal Hygid d other event, II	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden	Surname)	
Maryland	should be nd Menta marked umatic ev	10	TED SARKIN  19a. Informant's Name/Relationship (Type)	- Brintl	10h Mailin	Address (Street a		COHEN	0:1	T C4-4- 7:-	0.41
	and 2 sho ealth and n 27 ls m	0	FRED T. WILCOX HU			QUEEN E					,
re,	the the		20a. Method of Disposition	con	e of Dispos	ition (Name of atory or other plac	1	Date		cation - City or To	
Ĕ	Pages ment of ant: If it	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	noval from State		MORIAL P.		07/04	OLN	EY, MARY	T.AND
Baltimore,	permit. Pages Department of I Important: If its any injury or or once.		21. Signature of Funeral Service Licenses		ΨAN	Name and Addres ZANSKY G O ROCKVI	OLDBERG				
			23a. Pand Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.						_ MD . ZUO	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CARCINOMA C	F UNK	NOWN PRI	MARY			м	Onset and Death
	/Medical Examiner		resulting in death) a.	Due to (or as a conseque	nce of):						
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o,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):						
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O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal do 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗆	Ectopic pregnancy Other <i>(specify)</i>			2	3d. Date of delive Month	ry Day Year
7.	that thed by	/ Ph	Part II. Other significant conditions conti	ibuting to death but not resulti	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to th	e cause of death?
rds,	w requires been sign should be							1 □ Y	es 2X	No 3□Proba	ably 4 Unknown
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	ding h. After fune	tion: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation		Bb. Time of Injury	28c. Injury Work	at	28d. Describe h			HODI ICE
DIVISION	I or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hombuilding, etc. (Specify)	a, farm, stre			28f. Location (S City or Tow	treet and n, State)	Number or Rural	Route Number,
_	pital ours a neral I		29a. Certifier 1 <del></del>	ian: To the best of my knowle	dge, death	occurred at the tim	e date and place	e, and due to the	ause(s)	and manner as sta	ated.
	n 24 h n 24 h he Fun pletely	Medical	(Check only 2 Medical Examina one)	r: On the basis of examination and manner stated.	and/or invi	estigation, in my or	pinion, death occi	urred at the time, o	date and	place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	4	29d. Date	signed (Month, E	Day, Year)
	12		I Chihi yeym	el M.D.			42452		MAY	5, 2004	
			30. Name and address of person who com DR. CHITRA RAJAGOPA			rint) E PHILIP	, #328,	OLNEY, M	D 20	832	
••	Sta Registr		31. Date filed (Month, Day, Year) MAY 11 2004	32. Registrar's Signatur	B	Spark	/				

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	/ /Medic	al	Wayne Ste					45 005	T		4 D 45	May	8	2004		A ™
ħ.	Examin	er	4a. Facility Name (If no	_		mber)				Location of				County of Deat		
4.48			5. Social Security Number			7. Age (In yrs.	last birthday)	S11 If Under		Sprin		8. Date of Bir	th	ontgome	ry	te or Foreign
	Funeral Director		219-64-08	10%	1 M 2□F	4	* .	Months		Hours	Min.	0ct.30	y, Year)	4	untry) MT)	ite or Foreign
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	er de Items	Funeral	11. Marital Status	OF Married	Armed Fo		.S. 13. V	Nas Deced f Yes, spec	ent of Hi ify Cuba	ispanic Ori ın, Mexican	gin? (Spi n, Puerto	ecify Yes or No Rican, etc.)	-	<ol> <li>Race - Ame Black, White</li> </ol>		٦,
36	rs aft	by F	1 Never Married 3 Widowed 4		1 ∐ Yes If Yes, Gir Year or D	Ve		1 ☐ Yes 2	Z <b>∑</b> No	Specify:				Specify: Wh	ite	
P	filed within 72 hours after death with the Maryland Hygiene. thar then "naturel", or llems 23s or 28s-f ehow ent. It is Medical Ezar, it is the mailified at	ed	15.	. Decedent's Edi	ucation		16a. Deced	lent's Usua	I Occupa	ation			16b. Ki	nd of Business/		
212	Z nin Z na "na Wedi	Completed	(Specify of Elementary/Seconda	only highest grad	College (	1-4or 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	rk done d se retired	during mosi ()	t of work	ing				
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9	al Hy al Hy d oth	Be (	17. Father's Name (First	st, Middle, Last)						18. Mothe	r's Name	e (First, Middle	Maiden	Sumame)		
<u>a</u>	should be filed within 72 hours after death with the Marylan and Mently glene. Indexed other then "naturel", or Items 23s or 28e-f ehow unetic event. It a Medical Exal it is a rest be multived at	10	Clarence	W. Wilke	erson					Frie	eda 1	L. Kahl	e			
Maryland 21215-0036	2 shc and le my		19a. Informant's Name			Wife								r Town, State, Z		
	and ealth m 27 har tr		Charlotte .		Wilke					le Dr	., S:	ilver S		g, MD 2		
o o	Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 Supposition 2 □ C		Removal from	State Cat	Place of Dispo- emetery, cren e of H	sition (Narr natory or of	ne of ther plac	e)   1	lay .			cation - City or ver Spr.		
	tmen tant:		° 4 ☐ Donation 5 ☐	Other (Specify,		Gat	Cemet	erv			200					
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 le marka eny injury or othar treumetic.		21. Signature of Funera	al Service Licens	199		22	. Name an	d Addres	ss of Facilit	<sup>y</sup> Frai	ncis J.	Co1	lins Fu	neral	Home
	40204		23a, Part1, Enter the	ey / Am	lications that a	ausad the deat								Spring		
П			shock, or heart fa		ne cause on e	ach line.	n. Do not ente	ar the mode	a or dynn	y, such as	Cardiac (	or respiratory a	11651,		Interval Onset a	mate Between nd Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aı	d	ures									15 y	ears
	Examiner				Due to	(or as a conseq	uence of):									
S:		ē	Sequentially list condition if any, leading to immediate. Enter Underlying	ions, diate	b. Due to	(or as a conseq	uence of):									
	utad d ansit	Examin	that initiated events	19												
oʻ	be executad sician and burial-transit		resulting in death) Last		Due to	(or as a conseq	uence of):									
1760,	a X a	ical			d											
9	leath certificat attending phy I for use as the	Med	IF FEMALE:													I .
Вох	ath ce Itendi	an/I	23b. Was decedent pre	egnant		tcome of pregna pirth 2 Peta		Ectopic pr	egnancy				2	23d. Date of deli	very Day	Year
o.	the a	Physician/Med	1 Yes 2 No		4□Pregr 9□Unkn	nant at time of d own	eath 5	Other (spe	ecify)					Month	Day	1021
<u>م</u>	hat thid by	Ph	Part II. Other significar	nt conditions co	ntributing to d	eath but not res	ulting in the ur	ndertying ca	alice dive	an in Part I		23e Did t	nbacco u	se contribute to	the cause	of death?
Records,	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	d by			····-		<b>-</b>	,	g				Yes 2			Unknown
Ö	requ been shoul	Completed										24a. Was		·-		
Rec	Tha law ate has page 2 s	mp										auto		24b. Were aut prior to c death?	ompletion	of cause of
Vita		ပိ	25. Was case referred	to medical						OC Disco	of Dooth	1 Yes		1 🗆 Yes	2□ No	
5	Physicien: r this certifica ral director, p	o Be	examiner?	-	Hospital:	Inpatient 2 🗆	EB/Outnation	t 3 🗆 DO	Δ Othe			n <i>(Check only o</i>		6 □Other (Spec	ifu)	
of	g Phy ar this eral c	-	27. Manner of Death		28a. Date	of Injury	28b. Time of		Bc. Injury	/ at		28d. Describe			''y/	
<u>o</u>	Attending I r death. ector: After by the funer	atlo	1 Natural 5 2 ☐ Accident	E Pending investigation	(MOII)	th, Day Year)	Injury	М	Work	Yes 2□!	No					
Division of	or Attendater death Director: In by the	tific	3 ☐ Suicide 6	Could not be determined	286. Place	of Injury - At ho		eet, factory	, office			28f. Location (: City or To	Street and	d Number or Ru	ral Route A	lumber,
Ö	tal or rs afte el Dir ad in	Certification:			_ i	ing, etc. (opcon								·		
	To the Hospital or At within 24 hours after of To the Sunerel Directompletely filled in by	edical	29a. Certifier 1 (Check only 2	Certifying Phy Medicel Exam	sician: To the	best of my kno asis of examina	wledge, death	occurred a	at the tim	ne, date an	d place, a	and due to the	cause(s)	and manner as	stated.	e(s)
	To the h within 24 To the S complete	ledi	one)		and man	ner stated.										
		Σ	29b. Signature and title	or certifier	4.0			29c.	. LICONSE	number			zau. Dat	e signed (Month	, ∪ay, Yea	"
,	B		June 1d	y	10				1872	26			Ma	y 10, 20	004	
			30. Name and address					•	0.1	200	MT (	20022				
	Sta	te	Arthur Scho		- 1	rince P legistrar's Signa					PID 2	20032				
	Registr		MAY	13 200	4 51	mera	B	Spor	Kal	<i>y</i>						

			For State Registrer		Department of Health and Certificate of Death	Mental Hygi	ene 2001	15000
_					Certificate of Death		g. 110.	10009
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Yeer 2004	3. Time of Death
	/Medic		VIVIAN J	. WILLIAMS		MAY 8		6:55 A <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give s		4b. City, Town, or Location of Dea	ith	4c. County of Death	
			6909 23rd Aver		Hyattsville	9	PRINCE G	EORGES
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	Months Davs Hours Mir		Year) 9. Birthi	place (State or Foreign
0	Director		220-40-4/30	M - XLXI- 64	Yrs.	April (	5,1940 W	ash. DC
	p ,		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Tow	m or Location			Od. Inside City Limits
	aryla hov	_		Georges	Hyattsville			1X Yes 2 □ No
	Ba-f	ctc		debiges				
	iff th	Director	10e. Street and Number 6909 23rd Ave	nuo	10f. Zip Code 20783	10	g. Citizen of What Coul	ntry?
	72 hours after death with the Maryland fratural, or items 23s or 28s-f show digal Examinant be notified at	rai	0909 2310 AVE	illue			U.S.A.	
	e E	Funerai	11. Walta Status	<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	
9	or th	F	1 Never Married 2 Marned	1 ☐ Yes 2X No If Yes, Give	1 ☐ Yes 2 █XNo Specify:		Specify: B1	ack
8	urai',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				
5	72 h	Completed	15. Decedent's Educ (Specify only highest grade		<ul> <li>Decedent's Usual Occupation (Give kind of work done during most of w</li> </ul>	orking 1	6b. Kind of Business/In Dept. o	
2	or and thin	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired) Inco	ome	n.eq	Services
2	ygier ygier t.	Ö		4 yrs St	pervisor of Mair			OCT ATCC
2	d oth	Be	17. Father's Name (First, Middle, Last)	1		ame (First, Middle, M.	•	
yla	Men Men arke	ဥ	Hubert B. Gi			enia Ross		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury of other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street and Number or F		-	
≥,	and salth n 27		Larry Williams		909 23rd Ave., H			
Baltimore,	S to H		20a. Method of Disposition  XBurial 2 ☐ Cremation 3 ☐ Re	20b. Place of cemete	of Disposition (Name of ary, crematory or other place)	Date 2	0c. Location - City or To	own, State
Ĕ	Page of the second		'4 Donation 5 Other (Specify)	Good	Hope Cemetery 5	5/13/04	Silver S	oring, MD
Ħ	mit. Pertn sorts / Inju		21. Signature of Funeral Service License	PVIncelle	22. Name and Address of Facility	NOWDEN F	UNERAL HO	OME, P.A.
Ö	P F F P		TUNY Ne	DIGUE	146 N. Wash. St	, Rockv	ville, MD	20850
	, ¢		23a. Part 1. Enter the disease, or complic	ations that caused the deeth. Do	not enter the mode of dying, such as cardi	ac or respiratory arres	st,	Approximate Interval Between
	Dhusisian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	1 (1			Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	c Cancer			1 year
	Examiner			Due to for as a consequence	orj.			U
и		- C	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):			
	ted nsit	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	be executed ician and burial-transii	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence	of):			
760,	le be executed ysician and e burial-transit	calE						
687	law requires that the death certificate as been signed by the attending phys. 2 should be detached for use as the	dic	d					
×	ding se as	Physician/Medi	IF FEMALE:	Bc. If yes, outcome of pregnancy			23d. Date of delive	201
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
Ö	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	3 □ Other (specify)			
P.0.	that the deed by the detached		Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given in Part I	23e Did toba	acco use contribute to the	he cause of death?
ŝ	signed d be del	b	Status post	Yenal Trans	1 ' 1	1 ☐ Yes		ably 4 Unknown
50	w requir been si should l	ted	Illus pesi		79111	4		
ec	ne law has b	ple	Hypertensi	ion	/	24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
<u> </u>	T ate	Completed	HUPO thuro	1915m		perform 1 ☐ Yes 2	ed? death? 1 ☐ Yes	2 🗆 No
of Vital Records,	Physician: The this certificate ral director, pag	Be (	25. Was ca referred to medi 1 examiner?		26. Place of De	eath (Check only one	)	
<u></u>	S P	2	1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4 Nursing	Home 5 Resider	nce 6 Other (Specif	y)
	ding Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending		Time of 28c. Injury at 128c. Work?	28d. Describe how	v injury occurred	
<u>ō</u>	Attending r death. ector: After by the fune	atlc	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	or Attendate death Director:	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	Il Route Number,
	s after s after et Dire	Certification:						
	Hospitel 24 hours a Funeret I stely filled				e, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.			
	o the Hospitel or Attending Phythin 24 hours after death. It has Funeret Director: After the Sompletely filled in by the funeral	edical	one)	and manner stated.	and investigation, in my opinion, doubt occ			
	To the To the Complete	Σ	29b. Signature and title of certifier	+ - MA	29c. License number	29	d. Date signed (Month,	
	D		- Lung	7 100	20542		5-11-6	7
	(0		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print) 110 IRVING St. X	(11/ 11/	117018	
			JOSEPH CA	Tlett, MD	110 TRVING ST, N	, VV - YVA	Sh. VC.	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	4 /			
	Registi	ar	MAY 12 200	4 Jenewa	a sparks			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland		artment tificate			ınd M		giene Reg. No.	Z 1111	4 16890
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Esther V. Wol								2. Date of De Month May	ath Day	Yeer 2004	3. Time of Death 10:40P M
}	Examir	er	4a. Facility Name (If not institution, give s Wilson Health Car  5. Social Security Number 6. Sex	e Center	ge (in yrs. las	st birthday)	4b. City,		Gaith If Under 2	nerst		М	County of Dec	ery
	Funeral Director		299-12-7216 Usual Residence of Decedent	M 21XF	92	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, De Aug 9,		I <sub>1</sub>	rthplace (State or Foreign Jountry) Adiana
	the Marylan 7288-f show notified at	rector	10a. State         10b. County           MD         Montgom           10e. Street and Number	ery	10c. City,	Town or Lo Gai	thers					10g. Citi	zen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
036	d within 72 hours after death with the Maryland jiene. r than "natural", or tlems 23a or 28a-f show the Madinal Examiner must be notified at	by Funeral Director	301 Russell Avenu	e, #224 1 12. Was Decedent Armed Forces? 1  Yes 2 M If Yes, Give Year or Dates:	Ever in U.S.				·	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)		ited St 14. Race - Am Black, Wh Specify: T	erican Indian,
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			life. L	ent's Usual kind of work OO NOT usi	k done di e retired)	uring most	of workin	ng	16b. Ki	nd of Business	,
Maryland 2	be filed tal Hyg d otherwent,	To Be Co	17. Father's Name (First, Middle, Last)  Samuel P. McNa	aught					18. Mother	he1	(First, Middle,	ton	Sumame)	ation
d)	and 2 stealth ar		19a. Informant's Name/Relationship (Type Sandra L. Finfinis		er		Mocki	ngbi		urt,		Bri	dges, N	IJ 08887
Baltimore,	t. Page rtment c rtant: if		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)		cen	opoli:	tan C	<sub>rema</sub>	tory	Мау 200		Alex		, Virginia
Bal	Department of the position of		21. Signature of Funeral Service License  BACYA. The  23a. Part 1. Enter the disease, or complik	un)	the death	De		ark :	Drive	, Ga	ithersl	ourg	ral Hom , MD 20	10 East 1877
8760,	Physician /Medical Examiner  bhysician and physician and the phrial transit	icai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each li	a consequer a consequer	nce of):			/		e (nise		eau	Interval Between Onset and Death
P.O. Box 68	death certif e attending ed for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3 🗆	Ectopic pre Other (spe					2	3d. Date of de Month	livery Day Year
	sign sign d be	ed by PI	Part II. Other significant conditions con-							u		bacco us		o the cause of death?
al Records,	n: The law requicate has been rage 2 should		Porcraticiono	x. Par	tin	ce y	is de	sc	u	_	24a. Was autop perfor	sy med?/	prior to death?	utopsy findings available completion of cause of 2 No
ion of Vital	nding Physician: The la ath. r: After this certificate has e funeral director, page 2	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hi  27. Manner of Death  1  Natural 5 Pending investigation	ospital: 1  Inpatie 28a. Date of Inju (Month, Da	ent 2 EF	VOutpatient Bb. Time of Injury		Other	4 PNur	sing Hom	(Check only or se 5 Resid	ence 6		icity)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home c. (Specify)	e, farm, stre	et, factory,	office		2	8f. Location (S City or Tow	itreet and n, State)	l Number or R	ural Route Number,
	in 24 hour in 24 hour the Funeri pletely fill	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best er: On the basis o and manner st	f examination	edge, death n and/or inv	occurred a estigation, i	t the time in my opi	, date and nion, death	place, ai	nd due to the d d at the time, d	ause(s) a late and	and manner as place, and due	s stated. to the cause(s)
	Com To Mith	2	29b. Signature and title of certifier	recht	earf	lus		License		1			signed (Mont	
			30. Name and address of person who cor A RUBERT BIR				Print) Z	01 A 417	415R	SELL	CG, M1	1011	2087	217
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 14 2004		ar's Signatur سعم	5	Spar	KN	,					

16891

		Funer Directo	
HILDA WAINWRIGHT	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. mportent: If Item 27 is marked other than "naturel", or Items 23s or 28a-1 show any injury or other treumatic event, the Mardical Examiner in ust be maillised at	

Physici /Medic Examin

For

**Physician** /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

	1 - Stata Registrar	Cer	tificate of L	Death	Ra	ig. No.	UH	100	) !
	Decedent's Name (First, Middle, Last)				2. Date of Deat	h		3. Time of I	Death
in	HILDA PHILLIPS WA	INRIGHT			Month May	Day <b>Q</b>	Year <b>2004</b>	7 AM	М
al	4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death	Hay		y of Death	_/_AH	
er		ontor	-	Salisbury	, ма	Wico	_		
	Salisbury Nursing and Rehab C	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	WICO		lace (State or	Foreign
	1 M 2 M F CO	Yrs.	Months Days	Hours Min.	(Month, Day,		Cour	ntry)	roreign
2	217-30-9974				02/10/	1935	Mar	yland	
•		c. City, Town or Lo	cation				1	0d. Inside City	/ Limits
5	Maray I and Wiscomias	Caliab						1 v Yes	
act	Maryland Wicomico	Salisb							
ă	10e. Street and Number		10f. Zip Code		10	0g. Citizen of		ntry?	
<u>e</u>	200 Civic Ave.		21804	<u> </u>		US	A		
ne	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. V	Was Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-		ce - Americ		
E	1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 🙀 No	Specify:	1110411, 010.7			etc.	
Ď	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	'	TO THE ZIM NO	эр <del>в</del> спу.		Specia	y: V	hite	
ted	15. Decedent's Education	16a. Deced	lent's Usual Occupa	ation	20	16b. Kind of E	Business/In	dustry	
Completed by Funeral Director	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retired	luring most of worki )	rig				
E	12 -	Nurs	ing Assis	tant		Nursi	na Hoi	me em	
BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N				
8	Charles William Phillips			Hilda	Layte	าท			
70	19a. Informant's Name/Relationship (Type, Print)	10h Mailin	Address (Street	and Number or Rura			State Zin	Coda)	
	Susan A. Jackson/daughter			d.,Parsor		,		(0008)	
		0b. Place of Dispos							
	1 Burial 2 X Cremation 3 Bemoval from State	cemetery, cren	natory or other place	θ)		20c. Location	-		
	`4 □Donation 5 □ Other (Specify)	Salisbury	Cremator	cy = 5/12	/04	Salisb	ury,	MD	
	21 Signature of Funeral Service Licensee	22	Name and Addres	Funeral F	lome Pro	faccio	nal Δ	ecociat	ion
	David St. (Doman	CFSP !	501 Snow	Hill Rd.,	Salisb	iry, M	2180	04 04	-1011
	23a. Part1. Enter the disease, or complications that caused the		er the mode of dying	g, such as cardiac o	r respiratory arre	st,		Approximate	
	shock, or heart failure. List only one cause on each fine. Immediate Cause (Final							Interval Betwo	een eath
	disease or condition resulting in death)		10	ralh	1				
	Due to (or as a co								
	Sequentially list conditions, b.	Nu	Rec	•			4	0077	
lue	cause. Enter Underlying Cause (Disease or injury	ns quence of :					9		
me	that initiated events								
Ä	resulting in death) Last — Due to (or as a co	nsequence of):							
cal	d.								
/Medical Examiner									
Ž	IF FEMALE: 23c. If yes, outcome of pi					23d Da	te of delive	irv	
clar	23b. Was decedent pregnant in the past 12 months?  in the past 12 months?  4 Pregnant at time		Ectopic pregnancy Other (specify)			7	onth	Day Ye	ear
ysk	1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown 9 ☐ Unknown	50,000	Cities (specify)						
Completed by Physician	Part II. Other significant conditions contributing to death but no	at requiting in the	adorbina como	n in Bort !	220 Did t-t-	2000 1100 000	tributa ta t	0.00000 -1.4:	oth?
þ	Part II. Other significant conditions contributing to death but no	t resulting in the un	nderlying cause give	en in Part I.				ne cause of dea	/
ed					1 □ Ye	s 2 No	3 Prob	ably 4 🖽 n	known
Set					24a. Was ar		Were auto	psy findings av	vailable
Ē					autopsy	ed?	death?	npletion of cau	use of
ပိ					1 Yes 2	C-140	1 🗆 Yes	2 No	
Be	25. Was case referred to medical examiner?		Otho	26. Place of Death					
2	1 res 2 no	2 ER/Outpatient	-	4 Horsing Hor	ne 5 Reside			/)	
on	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Ye.	ar) 28b. Time of Injury	28c. Injury Work	at	28d. Describe ho	w injury occur	red		
at	2 Accident investigation		M 1 🗆 Y	res 2□No					
ţį	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S		eet, factory, office	1	28f. Location (Str City or Town		ber or Rura	l Route Numbe	er,
Ser	Danielly, etc. (5)	,,,							
Medical Certification: To	29a. Certifier 1 Certifying Physician: To the best of my	y knowledge, death	occurred at the tim	e, date and place, a	and due to the ca	use(s) and m	anner as st	ated.	
dic	(Check only 2 Medical Examiner: On the basis of examiner) and manner stated.	mination and/or inv	restigation, in my op	inion, death occurre	ed at the time, da	te and place,	and due to	the cause(s)	
Me	29b. Signature and title of certified		29c. License	number	29	d. Date signe	Month.	Day, Year)	
	28/1/		0 <	287,	-8	5/	12-	,	
	11/1/			1124		7/1	404		
	30. Name and address of person who completed cause of death	-		•	/	/			
	William H. Robins A	L.D.	1346 S. D	ivision S	St.Suite	Salis	bury,	Md.218	304
te	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature	Spar	V. 1					
ar	MAY 1 1 2004 Sene	D	ppour						

			1 - For State Registrar	State of	Marylan		artment rtificate				lental H	ygier Reg. N	20	04	16803
п	Physic	an	Decedent's Name (First, Middle, I	Last)							2. Date of D		)ay	Year	3. Time of Death
	/Medi		Zhiyuan Xi								May 6	, 20	004		10:30A M
10	Examir	ner	4a. Facility Name (If not institution, g		ber)		4b. City, T			of Death		4	lc. County o	f Death	
	E	44	8145 Morningvie  5. Social Security Number 6		7. Age (In yrs.	last hirthday)			burg If Under	24 Hrs.	9 Date of B	lirth	Montg		
ı	Funeral Director		218-47-0588	1 M 2□ F	56	Yrs.		Days	Hours	Min.	8. Date of B (Month, L April	Day Yea	1948	Chin	lace (State or Foreign try)
	ס		Usual Residence of Decedent										-> .0	OHIL	
	arylar show	-	10a. State 10b. County		10c. City	y, Town or Lo	ocation							1	Od. Inside City Limits
	he M	ecto	Maryland Montgo	mery	Gai	thersl									1∭Yes 2☐No
	with t	by Funeral Director	10e. Street and Number	D			10f. Zip 0		,				Citizen of Wi	nat Coun	try?
	heath	era	8145 Morningview	12. Was Deced	dent Ever in U	S 13		0877		gin2 (Sp	acify Vac or N		hina 14 Race	- Americ	an Indian
ယ္	or Iter	표	1 Never Married 2 Married	Armed Ford	ces? 2∭XNo				, Mexican	, Puerto	ecify Yes or N Rican, etc.)	10-		White,	
93	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show ilsel Examinat must be notified at	1 by	3	If Yes, Give Year or Da	tes:		1 Yes 2	X No	Specify:				Specify:	As	ian
5-0	72 h 'natu	Completed	15. Decedent's (Specify only highest of			(Give	dent's Usual kind of work	done di	urina most	t of worki	na	16b.	Kind of Bus	iness/Inc	lustry
121	within	m du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use	retired)					ernme		r the ublic of
d 2	filed Hygie ther ther	e Co	17. Father's Name (First, Middle, La	st)		Eng	gineer		18 Mothe	r's Name	(First, Middl	$_{ m Chi}$	na		
an	ld be ental ked o	To Be	Wenxin Xi	,							n Zhou	o, maioe	iii oumame,	,	
ary	shou nd M mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (	Street a			il Route Num	ber, City	or Town, S.	tate, Zip	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or oper treumetic event, the Mudical Examinat must be notified at once.		Sherry Xi/Daugh	ter							, Gait				20877
ore	S T S T S T S T S T S T S T S T S T S T		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	Demoval from S	l	lace of Dispo	sition (Name	of		May			Location - C		wn, State
Ë	Pag ment ent: I ury o		'4 □Donation 5 □Other (Spec			ntgomen matori	Lum, II	nc.	i_;	2004		Ве	thesd	a, M	aryland
3alt	ermit. Pepart nport ny inj		21. Signature Fulleral Service Lice	ө ѕа		22	2. Name and	Address	of Facility	Rob	ert A.	Pum	phrev	Fun	eral Home/
	40 = 9 Q		// Chine	leury	. M008	03 Be	thesd	a, M	ary1	and	20814	<b>-</b> 350	1 WI	SCOII	sin Avenue
l.	MILETONIE :		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on ea	ch line.	i. Do not ent	er the mode	or aying	, such as	cardiac c	r respiratory	arrest,			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	nyxiati									- 9	
В	Examiner				r as a consequ angulat										
		Jer	Sequentially list conditions, if any, leading to immediate		r as a consequ										
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Suic	eide										
30,	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (o	r as a consequ	uence of):									
8760,	death certificate be executed e attending physician and of for use as the burral-transit	Physician/Medical		d							_			-	-
9 X	eath certific attending pl	/Me	IF FEMALE:	23c. If yes, outco	ome of pregnar	ncv			1000					4 1 11	
Вох	atter f for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 Fetal	death 3	Ectopic preg Other (spec					Ì	23d. Date of Month		y Day Year
P.O.	that the de led by the detached	hysl	1 Yes 2 No 9 Unknown	9□ Unknow			(-,								
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions	contributing to dea	th but not resu	ılting in the ur	nderlying cau	se giver	in Part I.		23e. Did	tobacco	use contrib	ute to the	cause of death?
ğ	w require been sig should b										10	Yes 2	. <b>X</b> No 3	☐ Proba	bly 4 □Unknown
ecc	e faw r has be je 2 sh	Completed									24a. Was				sy findings available pletion of cause of
<u>~</u>	ate pag	Con									perf	ormed?	dea	ith? Yes 2	
Division of Vital Records,	Attending Physicien: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only				
of	S S	. To	1 X Yes 2 No 27. Manner of Death	)   int	patient 2 E	ER/Outpatien 28b. Time of	_	Univer	4 🗆 Nur	sing Hon	ne 5X Res	idence	6 Other	(Specify)	
on	ding th. Th. After funer	tion	1 Natural 5 Pending 2 Accident investigati	28a. Date of (Month,		10:30		Injury a Work?	at es 2.1∑TN						
VISI	or Attending Phatter death. Director: After thin by the funeral	ifica	3 ∑ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of	f Injury - At hor	me, farm, stre			21	-	Suicion (	Street a	nd Number	or Rural	Route Number,
Ö	i Çirle	Certification;	4 🖸 Homicide	building	, etc. (Specify,	Home				8	3145°Mc Saither	wn, Stat Ornii	ngviev	Dr	ive )877
	Hospitel 24 hours. Funerel tely filled	edical	29a. Certifier 1 Certifying F	Physician: To the baseminer: On the base	est of my knov	viedge, death	occurred at	the time	, date and	I place a	nd due to the	cause/s	) and mann	or ac cta	tod
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medi		and manne	r stated.					1 OCCURRE	d at the time,				
	To To Con	2	29b. Signature and title of certifier					icense i				29d. Da	ite signed (f	Month, D	ay, Year)
	(0							523	6			May	7, 20	004	
	Ψ		30. Name and address of person who		-		,	3741	1 o 10 d	1.0	#211	D 1		3.67	20052
	Sta	te_	Carl I. Margoli 31. Date filed (Month, Day, Year)	32. Fied	istrar's Signati	ure -				.ke,	# ZII,	KOCI	KVILLE	e, ML	20852
	Registr		MAY 102		never	B	Spar	K	*						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 19. 2004 Physician Yutzy 12:00 pm <sup>M</sup> Henry /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 509 Maryland Avenue Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 8. Date of Birth (Month, Day) Mar 19, 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ★M 2 F 214-12-3029 83 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23e or 28e-f ehow the Medical Exeminer must be notified at Allegany Cumberland MD 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 509 Maryland Avenue 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give WW II Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) machinist railroad 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any jury or other treumatic event 2008. Be Edith Minerd Yutzy Henry Yutzy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
509 Maryland Avenue Cumberland MD 21502 19a Informant's Name/Relationship (Type, Print) wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Sunset Memorial Park Date 20c. Location - City or Town, Stete 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/23/2004 Cumberland MD ^ 4 □ Donation 5 □ Other (Specify) 22. Nam Scarpelli füllerai Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Pert1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Slicepe 6 m Privsician /Medical Examiner 12 m. Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Examiner the burial-transit resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has 1 Yes 2 No RELEASED Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Chatural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 19.00 DO 8377 auceire 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uriel E. Velandia, M.D.; 902 Seton Drive; Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			-	State of Marylar	nd / Department of He	ealth and N	Mental Hyg	giene on	21 16001
		•	1 - For State Registrar		Certificate of D			Reg. No.	14 19834
	Diini		1. Decedent's Name (First, Middle, Las	t)	Λ.		2. Date of Dea Month	Day Ye	3. Time of Death
	Physicia Medic—		JESSE	WELLS	ADAMS		MAY	~~ ~~	04 11:30A
	Examin		4a. Facility Name (If not institution, give	1.1-	4b. City, Town, or I		05	4c. County of I	Death
	3		5. Social Security Number 6. S		Iast birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h 9.	Birthplace (State or Foreign
è	Funeral Director			M 2 F	Yrs. Months Days	Hours Min.	8. Date of Birth	Year	Country) MARVIAND
			Usual Residence of Decedent					7	
	ylanc how		10a. State 10b. County	10c. Ci	ty, Town or Location		0	/	10d. Inside City Limits 1    Yes 2 □ No
	Ba-1-	cto	MARYLAND 1	JA		TIMOR		Ty	
	or 2	Director	10e. Street and Number	1 - 1	10f. Zip Code	3100	<i>n</i>	10g. Citizen of Wha	_
	s 23s		2028 PENK	12. Was Decedent Ever in U	UE 13 Was Decedent of His	spanic Origin? (Si	O pecify Yes or No-		S A American Indian,
-	ltem Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🗷 No	If Yes, specify Cuban		o Rican, etc.)	Black, \	White, etc.
936	ours after death with the Marylan rel', or Items 23a or 28a-f show Examinar i dat be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates:	1 ☐ Yes 2 🔼 No	Specify:		Specify:	BLACK
215-0036	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f ehow disal Evantier cust be nailfied at	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occupal (Give kind of work done di life. DO NOT use retired)	tion uring most of wor	king	16b. Kind of Busin	ess/industry
2	- 50	Jd w	Elementary/Secondary (0-12)	College (1-4or 5+)	CHEM			Dinnun	EUTICAL CO.
121	should be filed withing Mental Hygiene. marked other than matte event, the M		17. Father's Name (First, Middle, Last)				ne (First, Middle,	Maiden Sumame)	EUTICAL
anc		Be c	TESSE	(DEL		TAN	THA	1	HDAMS
Maryland	d 2 should th and Men 7 is marke traumatic	၉	19a. Informant's Name/Relationship (	00-0	19b. Mailing Address (Street a	nd Number or Ru	ral Route Numbe	or, City or Town, Sta	
M	atth a		THANITA ADA	MS (WIFE)	2028 PEN	ROSEA	VE. BA	LTIHORE	MD. 21223
Je,	es 1 and 3 of Health filtem 27 r other tr		20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other place	9)	Date /	20c. Location - Cit	y or Town, State
altimore,	Pag ent In: I		1 🗷 Burial 2 □ Cremation 3 □  1 □ Cremation 3 □ Other (Specification)		RBUTUS CEMET	ERY 05-	27-04	BALTIM	ORE, MARULAND
alt	permit. Pag Department Important: eny injury once.		21. Signature of Funeral Service Licer	isee // VAA	22. Name and Address	s of Facility BA	ROUNT		ERAL HOME
8	20 E P 9	113	Lutiat.	N. Willia	2140 N.		ON AVE		0, MD, 21217 Approximate
г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	th. Do not enter the mode of dying	g, such as cardiac	or respiratory ar	1661,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Nummi					1W
4	Examiner			M M A AM (1)	quence of):	con	su)		6M
	77 A	er	Sequentially fist conditions, if any, leading to immediate	Due to (or as a consec		<			011
	uted d ansit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		<u></u>			
0	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
8760	ate be hysici the bu	lical		d					
89 x	death certificate t attending physi d for use as the b	Physiclan/Medi	IF FEMALE:	23c. If yes, outcome of pregn	ancv			23d. Date of	of delivery
Вох	attence for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet. 4 Pregnant at time of	af death 3 Ectopic pregnancy			Month	Day Year
o.	that the de ed by the detached	isic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown					
ط	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by PI	Part fl. Dther significant conditions of	ontributing to death but not re	sulting in the underlying cause give	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?
Records,	w require: been sig should bo	ed b					X	/es 2□No 3(	☐ Probably 4 ☐ Unknown
SCO	aw re	plet					24a. Was autop		re autopsy findings available or to completion of cause of
E E		Completed					perfo 1 ☐ Yes	rmed? dea 2 No 1	th? IYes 2□ No
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Linesite!	Otho		ath (Check only o	ne)	
of \	Physi this c	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	□ ER/Outpatient 3 □ DOA Othe 28b. Time of 28c. Injury	4   Nursing H		dence 6 Other of the following occurred	(Specify)
on C	ling After	ion	27. Manner of Death  1 Natural 5 ☐ Pending  2 ☐ Accident investigatio	(Month, Day Year)	Injury Work	(? Yes 2 □No	200. 2000100 1	ion injury occurred	
Division	Attending r death.  • ctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Pface of Injury - At h	nome, farm, street, factory, office	///			or Rural Route Number,
Ö	al or after	Certification:	4  Homicide	building, etc. (Spec	ny)		City or Tow	wi, State)	
	pspita hours unera ly fille		29a. Certifier Certifying Pl	nysicien: To the best of my kn	owledge, death occurred at the time ation and/or investigation, in my op	e, date and place	a, and due to the	cause(s) and mann	er as stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I	Medical	one)	and manner stated					
	To T To T	Σ	29b. Signatura and title of dertifier	NAME!	29c. License			29d. Date signed (/	-/04
	$\wedge$		WIT HUM	שיטיני	14	0160	1	1/25	101
			PETR HAUNER	completed cause of death (life	T 233 HTXPE PENE STE	EET BA	LITHORE	5/11 ZIZ	0/
	St.	ate	31. Open (and (4/open), Day Year)	32. Registrar's Sign					
à	Regist		WHAT & I LUUA	Town of	process				

DHMH 17 Rev 1/2001

		For	State of Maryland	/ Depa	rtment of H	ealth and			2001	16895	
		1 - State Registrar Certificate of Death Reg. No.									
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death	
/Med			ald E. Buckm	an			May	23	2004	8:30A <sup>M</sup>	
Exami	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or				County of Death		
		9210 Furrow Ave 5. Social Security Number 6. Sex	1UE 7. Ag <i>e (In yr</i> s. <i>I</i> as	t hirthday)	ELLL If Under 1 Year	cott C			loward	place (State or Foreign	
Funeral Director			M 2□F 76	Yrs.	Months Days	Hours Mi		1927	7 Per	place (State or Foreign ntry) nnsylvania	
/land		10a. State 10b. County	10c. City,	Town or Lo	cation				1	10d. Inside City Limits	
Man P-f sh	to	MD Howard	a El	lico	tt City					1 ☐ Yes 2 ☐XNo	
th the	lred	10e. Street and Number			10f. Zip Code	-		10g. Citiz	en of What Cour	ntry?	
23a vi	al	9210 Furrow Ave	nue		2104			ited S	tates		
IIII X IX 13-0030  be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, IX ME SIGHT Exprine that be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?			<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol>				o- 14. Race - Am <i>er</i> ican Indian, Black, White, etc.		
hours after	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1945 —	.50	□Yes 2/2 No	Specify:			Specify: Fath	ite	
thou stura	ed	15. Decedent's Educ	ation	16a Decer	lent's Usual Occupa	ation		16b. Kin	d of Business/In		
7 nin 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. l	kind of work done of OO NOT use retired	during most of w ()	rorking				
d with giene	Completed	12		Insu	rance S	alesma	n	Lif	e Insu	rance	
id be file ental Hy ked othe	Be	17. Father's Name (First, Middle, Last)					am <i>e (First, Middle</i>		Sumame)		
should be and Mental in marked o	To I	Emery Buckman			Sara Valentir						
IC, INICITY STATES 1 and 2 should I Health and Men Item 27 Is marke other traumatic	1	19a. Informant's Name/Relationship (Type Denise Buckman/I			g Address <i>(Street a</i> Bayber:			-			
s 1 and f Health item 27 other t						-	Date		ation - City or To		
in its		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	amovan from State	_	sition (Name of natory or other place	θ)					
Dalfill Dages  permit. Pages  Department of the Importent: If ite  any injury or of once.		' 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License			remator		26-2004			Family FH	
Department of the partment of	1	21. Signature of Pulleral Service Coerise	-17 7	100						City, MD	
MU ASS		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that sused the death.						110000	Approximate	
Dharisian		shock, or heart failure. List only on Immediate Cause (Final	1							Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)	HTHERUSCLE, Due to (or as a conseque)		UPHLOIV	V175002	AR D	1307	16		
Examiner											
BOX 00/00, eath certificate be executed attending physician and for use as the burial-transit	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Enter Underlying									
	Examiner	that initiated events C.									
/oU, e be exe /sician a e burial-		resulting in death) Last	Due to (or as a consequent	nce of):							
Sate b sate b shysic the b	dical	Q d									
Ords, P.O. BOX 68 requires that the death certificat een signed by the attending phy nould be detached for use as th	Physiclan/Med	IF FEMALE:	3c. If yes, outcome of pregnance	.,							
BOX bath cer attendir for use	lan	in the past 12 months?	Ectopic pregnancy Other (specify)			23d. Date of delivery  Month Day Yea		*			
bed the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of deal 9□ Unknown	ui 3 _	Other (specify)						
COLOS, P.C w requires that it been signed by should be detac	'Ph	Part II. Other significant conditions con	tributing to death but not resulti	ng in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco us	e contribute to th	he cause of death?	
d Sign	d by	DEMENTIA					1 🗆	1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown			
2 20	lete						24a. Was	an	24b. Were auto	psy findings available	
The law rate has b page 2 s	Completed							rmed?	prior to co death?	mpletion of cause of	
(9 -	Ö	25. Was case referred to medical	7,72			26 Place of D	1 ☐ Yes eath (Check only		1 ☐ Yes	2   NO	
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	0 8	examiner?	ospital:	enital:				ome 5  Residence 6 □Other (Specify)			
	I.:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	28d. Describe	28d. Describe how injury occurred				
	atlo	1 Natural 5 Pending 2 Accident investigation	M 1 ☐ Yes 2 ☐ No								
r Att vr Att ter de irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
urs af							1				
Hosp 24 hol Fune tely fi	Medical		ician: To the best of my knowler: On the basis of examination and manner stated.								
o the ithin 2 o the smple	Med	29b. Signature and title of certifier	and mariner states.		29c. License	number .		29d. Date	signed (Month,	Day, Year)	
F 3 F 8		Yelan	ims		0000	05-6	0	Ma	v 24	2004	
di,		30. Name and address of person who co		3a) (Tyne				ına.	Y 47,	2004	
10		PANKAT CHETERI	AU 201-109	Λ .	IL RIVE	EB N	DECK !	24.	BALTIN	2004	
S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Θ ,	,						
Regis	trar	MAY 2 7 200	Arma	19	Spork	/					

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar	State of Maryland	/ Depa	rtment of F	lealth and Death	Mental Hy	giene 2 (	004 16896	
Physic /Med		Decedent's Name (First, Middle, Last)     Jerry		E	Bethea :	Jr.	2. Date of De Month	Day 25	Year 2009 1:45 AM	
Exam		4a. Facility Name (If not institution, give :	Balhmore		Balhir	r Location of Dea	4		ty of Death	
Funera Directo		5. Social Security Number 6. Sec 218-60-8136	7. Age (In yrs. las XM 2□F 50	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		ay, Year)	Birthplace (State or Foreign Country)     MD	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23e or 28e-f show other traumatic event, the Maclical Evanthar must be notified at	tor	10a. State 10b. County  MD NA		Town or Loc					10d. Inside City Limits 1	
	i Direc	10e. Street and Number		10f. Zip Code	215		10g. Citizen of What Country? U • S • A •			
	by Funeral Director	3533 Reisterstor  11. Marital Status  1 Never Married XIX Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give		Vas Decedent of H Yes, specify Cuba		Specify Yes or No rto Rican, etc.)		ice - American Indian, ack, White, etc.	
	Completed b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)					orking	16b. Kind of Business/Industry		
	Be Com	12th grade 17. Father's Name (First, Middle, Last)	na	Sto	ce Mana		me (First, Middle	L	ate Business	
	To	Jerry Bethea Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural R								
ges 1 and 2 t of Health If Item 27 or other tra		Mary J. Crump-Si. 20a. Method of Disposition 1 Disposition 3 □R	20b. Plac	ce of Dispos	Reiste ition (Name of atory or other place		Road,		ore Md 21215 - City or Town, State	
permit. Pages 1 and 2 Department of Health 8 Importent: If Item 27 In any injury or other tra		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	Mt.	22	n Cemet Name and Addre Name and Addre 1300 Wa	s of Facility	- 5		ore, Md Md 21215	
Physiciar /Medica		23a. Part 1. Enter the disease, or complishock, br heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  A. Pheumonia	Do not ente					Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attended to the Attending Physician and to the Funeral Director: Attending the funeral director, page 2 should be detached for use as the burial-transit or completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or the funeral director.		Sequentially list conditions, if any, leading to immediate cause Enter III July 18 Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent Due to (or a) (	nce of):					Unknun	
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 reenths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deal 9 □ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)	·			ate of delivery onth Day Year	
	by	2							use contribute to the cause of death?	
	Completed	V					24a. Was autoj perfo 1 🗆 Yes	osy ormed2	Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No	
	tion; To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending  2 ☐ Accident investigation	M					y one) sidence 6 □Other (Specify) se how injury occurred		
	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined					28f. Location (Street and Number or Run City or Town, State)			
	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To the To the comp	W	29b. Signature and title of certifier			29c. License		1	29d. Date signed (Month, Day, Year)		
1)		30. Name and ad less of person who co	mpleted cause of death (Item 2:	3а) (Туре, Р	(rint)	AL HOS	PHAI	DE BA	5, 2004 LTIMURE	
S <sup>.</sup> Regis	tate trar	31. Date filed (Month, Day, Year)  MAY 2 7 2004	32. Registrar's Signatur	4	1		+ + +			

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Patient Upon as: Jerry Betheu Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND ITEM #1 PER PHY C831 5/27/04 De ertificate of Death 1. Decedent's Name (First, Middle, Last) MELVIN BONAPARIE, SR. 2. Date of Death **Physician** SY 10 .004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AbspitAL BALTIMORE (
If Under 1 Year | If Under 24 Hrs. | Johns Hopkins 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 0 Months 1**№** М 2□ F Days 219-56-5241 Usual Residence of Decede 10a. State 10b. County Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 21206 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indian. Black, White, etc. 1 Pes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Specify: B/A 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be BONDPARTE ဂ္ 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) DARTE JV. 20b. Place of Disposition (Name of State 21221 20a. Method of Disposition cemetery, crematory 1 Burial 2 Cremation 3 Removal from State ViewCrem \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 2000 Con 23a. Part1. Enter the disease or complications the disease shock, or heart failure. eist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition END-STAGE LIVER DISEASE 2 WEEKS resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) I□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 XNo Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 2XNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1XInpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 🗌 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

The law requires that the death certificate be executed burial-Box 68760 as the l attending esn ŏ o. detached signed I Records, page 2 certificate Division of Vital Hospital or Attending Physician: ē this e Hospiter ... in 24 hours after dean... Fringrel Director; Afr To the

**Funeral** 

Director

or 28a-f show

or Items 23a death

"natural"

al Hygiene.

Mental and Mental

f Health item 27 l

to I

**Physician** 

/Medical

**Examiner** 

0 permit, Page Department of Important: If any injury or

other traumatic avant, the Medical Examinar must be nutitled at

with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NEIL AGGARWAL, 600 NORTH WOLFE STREET, JOHNS HOPKING HOSPITAL, BALTIMORE, MARYLAND ZIZET 32 Registrar's Signature

, MEDICAL DOCTOR

and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

2004

MAY, 10,

**ORIGINAL** 

04-3417 Unpend Item#23a,27,28a-f,PER ME,C832,6/2/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S MARTHA ANN COFFEY State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** MAY 21, Martha Coffey Ann 0724 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6503 CRESTWOOD ROAD TOWSON

If Under 1 Year If Under 24 Hrs. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) **Funeral** Months. Days Hours 1 □ M 2 🖾 F 43 Yrs. Director 219-86-3013 NOV 6. Georgia Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Towson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6503 Crestwood Road 21239 238 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4or 5+) 5 + Elementary/Secondary (0-12) School Psychologist Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be nd Mental Joseph Henry Coffey, Sr. Joyce Catherine Kendall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trau once. Joann Catherine Coffey/Sister 712 S. Beechfield Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 5-26-04 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation Society of
2.55 Frederick Road MD. Inc. Baltimore, MD Thomas Gregor ( 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Mixed Drug (zolpidem, trazodone, oxycodone, and a acetaminophen) intoxication Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transil Due to (or as a consequence of): sician Box 68760. Physician/Medical use as the attending phy IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₫ cate has been sig page 2 should b 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 No 2 No autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No AT SCENE this Certification: 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After found 5/21/04 1 Natural 5 Pending found 7:15a subject ingested drugs 1 ☐ Yes 2 🗷 No investigation 2 Accident hours after death uneral Director: 6 Could not be determined 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or found at home 6503 Crestwood Rd., Towson, MD within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E MAY 21, 2004

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State

Registrar

30 Name and address of person who completed

2 7 2004

31. Date filed (Month, Day,

RONGA Year)

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

pe or Print in Black Indelible Ink. Ensee All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2004 MADORA CHANCY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MERCY MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 59 214-44-7941 131/45 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant; if item 27 is marked other than "natural", or items 23a or 28a-f ahow ant; if item 27 is marked other than "natural", or other traumatic event, the Modical Examinar must be notified at 1 Xes 2 No Directo Baltimore NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 U.S.A. 3719 Woodridge Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tremont Plaza Hotal Cook 12th grade na Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Paul Odoms Evelyn Buck ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3719 Woodridge Road, Baltimore Md Paul Chancy-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State permil. Page Department of Important: If any injury or once. King Memorial Park 5/29/04 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig 22. Name and Address of Facility March F/H West as 21215 4300 Wabash Ave, Baltimore Md complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final slmonus **Physician** disease or condition resulting in death) /Medical Examiner 2 Socientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Day in the past 12 months?

1 Yes 2 No
9 Unknown Month jo 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 should be 2☐No 3☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA ٩ ð this After the 28a. Date of Injury (Month, Day Year, 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a t 🗀 😅 Titfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2004 D40854 M completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who St Puri PI Baltimas 21203 Persobers 30) , MD NJ . 9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State south Registrar 7 2004

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For 1 = State Registrar	State of N	Marylan		rtment of H				giene Reg. No.	2001	160	200
	Physici /Medic	al		ard	nel .	Cost	4b. City, Town, o			2. Date of Dea Month May	23,		3. Time of 4am	Death M
	Examin Funeral Director	er		& Rehabil		ast birthday)		imore	<u> </u>	8. Date of Birt (Month, Da Apr 14	h y, Year)	Baltim		r Foreign
	D	or	Usual Residence of Decedent  10a. State  MD  Balti	more	10c. City	, Town or Lo				<i>пр</i> і 14			10d. Inside Cit	•
	ath with the 1 23a or 28a- ust be notifi	ral Director	10e. Street and Number 3712 Downey Dal	1			10f. Zip Code 211			10g. Citizen of What Cou				
960	72 hours after death with the Maryland natural', or Items 23a or 28a-f show deal Examinatroust be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ∰idowed 4 □ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give	es? If Yes, specify Cuban, Mexican, Puerto Rica  \[ \bigcap \cdot						y Yes or No- an, etc.)  14. Race - American Black, White, etc Specify: Whit			
21215-0036	- 2 33	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-40	or 5+)	16a. Deced (Give life. 1	ent's Usual Occup kind of work done DO NOT use retired Mason	ation during mos d)	st of workin	g	16b. Kind of Business Masonry			
ᅙ	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Lass Clarence Cl 19a. Informant's Name/Relationship	10h Mailia	a Addrasa (Street	Ge	eneva	Collin	iddle, Maiden Surname)					
ore, Mai	permit. Pages 1 and 2 should be Department of Health and Monta Important: If item 27 Is marked any injury or other traumatic e ang.e.		Mr. Clenard Cost  20a. Method of Disposition  1X Burial 2 Cremation 3	ley, Jr.	20b. P	3712 lace of Dispo- emetery, cren	Downey sition (Name of natory or other place	Dale	Dr.,	Randal	1stc	own, MD	21133 Town, State	
Baltimore,	permit. Pag Department Important: I any injury c		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	ify)	Fai	22 F	Church C ATCHT FU ykesvill	NERAL	ty HOME	E & CHA	PEL.	PA (Bo:		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a	sed the death ine. as a consequ	Do not ente	CONTRACTOR OF STREET	ng, such as		respiratory ar			Approximate Interval Bett Onset and D	ween Death
3760,	ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury that initiated events resulting in death) Last	c	or as a consequence of): or as a consequence of):									
O. Box 6	Attending Physician: The law requires that the death certificate be executed refath. refath. setor: After this certificate has been signed by the attending physician and better this certificate as the burial transit by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALÉ: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal t at time of de	Ideath 3	Ectopic pregnancy Other (specify)	у			23d. Date of deline			'ear
rds, P.	w requires that i been signed by should be deta	by	Part II. Other significant conditions	0 10	but not resi		nderlying cause giv	ven in Part	l.		obacco u /es 2	se contribute to	the cause of d bably 4 □U	
al Records,	n: The law re licate has be r, page 2 sh	Completed								1 ☐ Yes	rmed? 2 KNo	death?	ompletion of ca	available ause of
Division of Vital	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpe		ER/Outpatien 28b. Time of Injury	28c. Injui	ner: 4 ZN	ursing Hom	(Check only one 5 ☐ Residence 8d. Describe h	dence (	6 □Other (Speci y occurred	ify)	
Divisi	tal or Atten s after deat al Director: ed in by the	Certification:	2 Accident investigation of Could not determine	be 28e. Place of	Injury - At ho etc. (Specify		eet, factory, office		2	8f. Location (5 City or Tox		d Number or Rur )	al Route Num	ber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medicai		Physician: To the be eminer: On the basis and manner	s of examina			opinion, de		d at the time,	date and		to the cause(s	)
•	¥.2 ± 8		30. Name and address of person wh	a completed cause of	of death (Item	n 23a) (Type,	ſ	737	573		A.A		1,500,	)
	Sta	ate	Jef Zibell ) 31. Date filed (Month, Day, Year)		Maw istrar's Signa	ture A	Print) Rei	stevs	town	M	7 (	21136		
	Regist	rar	MAY 2 7 2	004	-	/-	/							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	for State Registrar	State of Ma	iryiana /	-	ment of i			giene Reg. No.	0001			
	7	Decedent's Name (First, Middle, Last)						2. Date of De Month	ath	2004	3. Time of Beach		
Physicia /Medic		Betty R.	Carter					May	26,	2004	7:00 a M		
Examin		4a. Facility Name (If not institution, give s	treet and number)		45	o. City, Town,	or Location of Deat	h	4c.	County of Death			
		Augsburg Luthera  5. Social Security Number 6. Sex		(In yrs. last bi	irthday) If	Balti Under 1 Year		8. Date of Bir	h	Baltin			
Funeral Director			M 2[X]F	86		onths Days			y, Year)	918 Ma	place (State or Foreign intry) iryland		
anyland •how	7	10a. State 10b. County		10c. City, Tov							10d. Inside City Limits 1 ☐ Yes 2 No		
he M	Director	Maryland Baltimo	re			sville			10a Citi	zen of What Cou			
th with 1		3408 Slade	Avenue			Tor. Zip Code	21208		10g. O	U.S.A	-		
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland of other than *retural*, or items 23s or 28s-f ehow event, the Medical Eratic act must be notified a event, the Medical Eratic act must be notified.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 23€ N If Yes, Give Year or Dates:			Decedent of s, specify Cul	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ameri Black, White Specify: Wh			
72 hour	eted t	15. Decedent's Edu (Specify only highest grade	cation	16a	(Give kind	's Usual Occu	during most of wo	rking	nd of Business/Ir				
an y lain A L L L L L L L L L L L L L L L L L L	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		<i>NOT</i> use <i>retir</i> er Pri			MD :	State Po	lice		
be filed ital Hygid of other	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)											
Menta Menta	To	Wilson H. Carter, Jr. May Gaigler											
vical 12 sh h and 7 ls m traum	3 15	19a. Informant's Name/Relationship (Ty) Stuart W. Carter	<sub>рө, Print)</sub> Nephew		•		tand Number or R 3rd Place						
Definition of the print print print print permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic events.	17 23	20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ R		20b. Place	of Dispositio	on (Name of ory or other pi		Date		cation - City or T			
it. Page itment intent: If njury or		*4 □Donation 5 □ Other (Specify)		Druid		The second secon	tery 5/2			esville,			
Depa Depa Impo eny li		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136											
50.3		23a. rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Occasional Death of Death and Death of Death and Death occasional Death											
Physician /Medical		mm flate Cause (Final lisease or condition esulting in death)  Due to (or as a consequence of):  Onset and Death 1-2 years  Meterstisis											
Examiner		Due to (or as a consequence of):											
7 5	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
avecut al-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
ificate be executed physician and as the burial-transit	edicai E	d											
J = 72		IF FEMALE:	120 If you system o	of pro-positive									
death certified attending	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 🗆 Yes 2 🔼 No	3c. If yes, outcome of 1 ☐ Live birth 3 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		topic pregnanther (specify)	су			23d. Date of delive Month	very Day Year		
at the d by the etache	Phys	9 Unknown			:- Ab		one in Dani	220 Did	obacca u	una apatributa ta	the cause of death?		
w requires that the death cer been signed by the attendin should be detached for use	þ	Part II. Other significant conditions cor	itributing to death bu	it not resulting	in the unge	rrying cause g	ven in Part I.		Yes 2		bably 4 Unknown		
To the Hospital or Attending Physician: The law requires that the death certive the hours attending Physician: The law requires that the death certive the hours attended to the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Completed								med?	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of		
lan: Jan: Tiflical	a	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only o	2 <b>5</b> No ne)	10,163	2010		
hysica his ce I direct	To B	examiner? 1 ☐ Yes 2 5 No	fospital: 1 🗀 Inpatier	nt 2□ER/O	Outpatient	3 DOA	1,400	dome 5 🗀 Resi	dence (	6 ⊡Other (Speci	ify)		
ding Pl		27. Manner of Death 1	28a. Date of Injur (Month, Day	y Year) 28b.	. Time of Injury	28c. Inj W	ury at ork? ☐ Yes 2 ☐ No	28d. Describe	now injur	y occurred			
or Atter after dea Director	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		farm, street,	factory, office	•	28f. Location ( City or To			al Route Number,		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier Check only one) Certifying Physical Examinates	sician: To the best of ner: On the basis of and manner sta	examination a									
To the within To the	Me	29b. Signature and title of certifier				29c. Licer	nse number		29d. Dat	e signed (Month.	. Day, Year)		
		<b>\</b>	-	$\supset$			03227	2		May Z	6, 2004		
5		30. Name and address of person who co	1		(Type, Prir	) ' \	\	1010					
		Jef Zucil M 31. Date filed (Month, Day, Year)		rs Signature	, ,	(eister	otown .	MV 21	136				
Sta Registr			7 2004	4.0	id	Kark							

Dennis Curtis 04-0 MAN

	3254		For Amend & Hon	end TState of	Manyland/	Depart	ment of H	ealth a	rst Ma	ental Hy	giene /	2001	1 600	
N			1 - State Registrar	endi Itemi#20a	C,220,27,2	Certif	icate of L	Death	/2//0	r cas	Reg. No.	2004	1690	2
	Physici	an	Decedent's Name (First, Middle							2. Date of De Month	Day	Year	3. Time of Death	
	/Medic	cal	Dennis Cu		201	4h	o. City, Town, or	Logation	f Dogth	May 1			2119 P	VI
	Examin	ier	Prince George!				Chever!		Death			ounty of Death	orge!s	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last bi	irthday) If	Under 1 Year	If Under 2	24 Hrs.	8. Date of Birt	h	9 Rintho	lace (State or Foreign	gn
	Director		577-94-7951	1 <b>X</b> M 2□F	42	Yrs.	onths Days	Hours	Min.	(Month, Da Oct 19	196	1 Mary	land	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Location	on					1	0d. Inside City Limit	rs.
	Maryli f sho	tor	MD Princ				1 ☐ Yes 2√ N							
	r 280	irect	10e. Street and Number		10g. Citize	on of What Cour	itry?							
	th with 236 o	al D	12814 Asbury D	rive			20	0744			USA			
	r dea	ner	11. Marital Status	12. Was Decede Armed Force ied 1 \( \subseteq Yes 2	nt Ever in U.S.	13. Was	Decedent of Hi	spanic Orig n, Mexican,	in? (Spec , Puerto R	cify Yes or No- lican, etc.)	14	Race - Americ Black, White,		
36	rs afte	by Funeral Director	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes Give		1 🗆	Yes 2 No	Specify:			S	pecify: b1	ack	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Items 23e or 28e-f show ant, I've Medical Exact. Item matter notified at		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)								16b. Kind	of Business/Inc	dustry	
215	htn 7.	Completed		st grade completed) College (1-46	or 5+)	life. DO	d of work done d NOT use retired,	luring most )	of working	g	infor	nformation		
21	e filed withtn al Hygiene. I other than '	Con	Elementary/Secondary (0-12)	1		techn	ician			<b>(5)</b>		nology		
and	t be fill he ded out	Be	17. Father's Name (First, Middle, Xavier							(First, Middle, Theres				
Ž	s 1 and 2 should be filed v f Health and Mental Hygie item 27 is marked other t other traumatic event, II	ဥ	19a. Informant's Name/Relations	b. Mailing A	ddress (Street a					Town, State, Zip	Code)			
	and 2 sealth ar		Marcelle Curti	ls/spouse	e 12814 Asbury Drive Fort V								0744	
Jre,	of Health item 27		20a. Method of Disposition	0.00	comete							wn, State		
<u>E</u>	Page nent o ent: If ury or		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 20 Other (S	pecify) in stat	e Pleasant	t Valle	y Mem. Pk	. 5	-28-04			ale, Va		
Baltimore,	permit. Pages Department of t Importent: If ite eny injury or of		21. Signature of Eunera Service Ropald	Licensee Di	gector_	DLA	re unarc					Company of the second of the s	So. Shirlin	gb
	40500		23a. Part1. Enter the disease, or	// Core	and the death. Do		imore,			-Rd., At		on, Va	Approximate	
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	n line.		is mode or dying	g, 30011 a3 c	Jardiac Of	163piratory at	1631,		Interval Between Onset and Death	
}	Physician . /Medical		disease or condition resulting in death)	a	Intoxicati as a consequence									
	Examiner		On the first one distance	b										
	D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence	of):								
	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	as a consequence	of):								
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai E												
687	ificate g phys as the	edic		d										
ŏ	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregnancy 2 - Fetal death	h 3∏Ect	opic pregnancy				230	d. Date of delive		
). B	e deat he att	sicis	in the past 12 months?  1 Yes 2 No		at time of death		her (specify)					Month	Day Year	
P.0	that the de ted by the detached		9 ☐ Unknown  Part II. Other significant condition	ons contributing to deat	h but not resulting	in the under	riving cause give	en in Part I		23a. Did to	bacco use	contribute to th	e cause of death?	
ds,	uires t signe ld be	d by	, a.c., a.g., a.g.,		-		.,g 02200 g				'es 2 □ I			n
ecords,	w requ	ompleted		-						24a. Was	an 2	24b. Were autor	osy findings available	Θ
$\alpha$	he age	omp								autop perfor	med?	death?	npletion of cause of 2 □ No	
Vital	ian: T	25. Was case referred to medical examiner?  Description:    Column												
of <	Physician: this certific al director,											Other (Specify	)	
	fter	lon:								3d. Describe h <b>Inknown</b>	ow injury o	occurred		
Division	Attending r death. sctor: After by the fune	ertification:	2 Accident investigation 3 Suicide 5 Could not be determined 4 Description 1 Suicide 4 Description 28e. Place of Injury - At home, farm, street, factory, office								treet and b	Number or Rura	And Central	_
Ο̈́	al or safter	Serti	4 Homicide Adetermined building, etc. (Specify)  Street								n, State) c <b>leight</b> s	s, Md	and Central	AV
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	calC	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pla companient of the basis of examination and/or investigation.								ause(s) an	nd manner as st	ated.	
	the H hin 24 the F nplete													
	To To	4	296. Signature and title of certifier  O.C.M.E.									signed (Month, $14$ , $200$		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								- I-IUY	14, 200	<i>y</i> <b>I</b>	$\dashv$			
	W	}	ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201											
9	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature											
	Registi	rar	MAY 2 7 2004	aner	- 1	Spa	the							

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** RIN LARTER 1:10 23 2004 MAG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Geneva Howar Howmal lumbla County If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 74-130 1 M 202 F 215 3 Director Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Glen 10g. Citizen of What Country? 10e. Street and Number 6455 21061 03 or Items 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic avent and once. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WENDO Swow 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MM 21061 20b. Place of Disposition (Name of cametery, crematory or other place) Colonial (olen Date 20a. Method of Disposition 20c. Location 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) en 22. Name and Address of F 21. Signature of Funeral Pervice Censee 50 10515 es 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BrEAST **Physician** METASTATIC YEURS /Medical Due to (or as a consequence of): **Examiner** Scuentially list modices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 🗆 Yes 2□ No 1 Yes 2 0 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🛣 No Medical Certification: To 1 Inpatient 2 EN/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direc filled in by 4 - Homicide Abepital ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) within 24 To the Fu and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D38500 rewritatio may of death (Item 23a) (Type, Print) akos 11065 Little Paraxen T Ptry Columbia MD 21044 Nichelus Li 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Laurence George Drew 04-03111 MAN

unpend item#23a,27,28a-f,PER ME,G833,7/2/O4eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental	Hygien <b>e</b> )	n	n	-
Certificate of Death	Reg. No.	U	U	

/	1. Decedent's Name (First, Middle, Last)
Physician /Medical	Laurence
Examiner	4a. Facility Name (If not institution, give s
	1463 Berger Stree

4a. Facility Name (If not institution, give street and number) 1463 Berger Street 5. Social Security Number 6. Sex 14 M 2 ☐ F

212-64-2350

Laurence George Drew

7. Age (In yrs. last birthday) Months 48

4b. City, Town, or Location of Death Odenton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year) FEB 11, 19

2. Date of Death

2004

4c. County of Death

May 07.

Anne Arundel Birthplace (State or Foreign Country)

16904

3. Time of Death

2200 P M

1 ☐ Yes 2 X No

Approximate Interval Betw Onset and Death

Day

2 🗆 No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 08, 2004

1463 Berger St., Odenton, MD

unknown

111 Penn Street, Baltimore, Maryland 21201

**Funeral** Director

show and be notified at Director 28a-1 ŏ or items 23a Be Completed by Funeral

deeth with filed within 72 hours after nit. Pages 1 end 2 should be filed within 72 hours al arment of Heath and Mental Hygiene. ortent: if item 27 is marked other then "natural; on injury or other treumatic event, its Medical Each

any inj

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

To the Hospital or Attending Physicien: The law requires that the death certificate be executed **burial-transit** the as пsе ned by the atter detached for L funeral death. after death Director: the in by

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

29b. Signa

4 Thomicide

31. Date filed (Month.

5 Pending investigation

6X Could not be

title of certifier

MAY 2

determined

Division of Vital Records, P.O. Box 68760,

1956 Japan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1463 Berger Street 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Never Married 2 Married 1 ☐ Yes 2 No Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Taxi Driver Taxi Service 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Othneil V. Drew Margie J. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Drew Greenberg/sister 142 Overlea Road Millersville, MD 21108 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory Inc. 5/25/04 Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21. Signatur (of Fu) Sepured imposed 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Methadone Intoxication Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 🗆 No res. Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) At SCENE Hospital: 1 XYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral Completely filled

Medical

State

Registrar

28b. Time of Injury

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

unknown

M

1 ☐ Yes 2 🙀 No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OCME

29c. License number

28a. Date of Injury (Month. Day Year)

Found 5/7/04

home

7 2004

State of Maryland / Department of Health and Mental Hygiene 2004 1690	_

		State of Maryland	Certificate of	Death	Reg. N		16905				
Physician	1. Decedent's Name (First, Middle, Last			2		ey Year	3. Time of Death				
/Medica	Ruby Mae Dumi: 4a Fecility Neme (If not institution, give			4b. City, Town, or Local		c. County of Death	7:00 pm				
/ Examiner	Westminster Nurs		tative Ctr.	Westminst	er	Carro	11				
Funeral Director	5. Social Security Number 6. Se			Hours Min.	Date of Birth (Month, Day, Year Ct 14,190	7) 9. Birth Cou	place (State or Foreign intry) T Virginia				
	Usuel Residence of Decedent										
arylen bhow	10a. Stete 10b. County		Town or Location	Hammatand			10d. Inside City Limits 1 ☐ Yes 2√ No				
vith the Ma	Maryland Carrol	1	10f. Zip Code	Hampstead	100.0	Citizon of Milat Cou	of Whet Country?				
with t		Court	Tot. 2ip Code	21074	log. C	USA					
death	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of	Hispenic Origin? (Specif can, Mexican, Puerto Ric	y Yes or No-	14. Race - Ameri					
Nore, Maryland 21215-0020 ges 1 and 2 should be filled within 72 hours efter death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be indiffed at	1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2√2 No		an, etc.)	Black, White,	white				
72 ho	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usual Occu (Give kind of work done	pation during most of working ed)	16b.	Kind of Business/Ir	ndustry				
21215-0	Elementery/Secondary (0-12)	College (1-4or 5+)	Vife. DO NOT use retire	ed)		al					
High A	17. Fether's Neme (First, Middle, Last)		Harbe	18. Mother's Name (/	First, Middle, Maide	en Sumame)					
ylancy build be fill Mental H wrked out	Dr. Benjamin McIntire  Sarah J. Roberts										
Maryland 212 d 2 should be filed with th and Mental Hygiene. 7 ta marked other than traumatic event, tre.											
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filled within 72 hours et bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or my injury or other traumetic event, the Medical Examples.	20a. Method of Disposition 1☆ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,	Removal from State	ce of Disposition (Name of netery, crematory or other place).		/24	Location - City or T					
Baltimo permit. Pag Depertment Important: I any Injury o once.	21. Signature of Funeral Service Licens		22. Name and Addr		ine Funer	al Home					
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death.			-	, 12 21	Approximate Interval Between				
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a. Atheroso	as a consequence of):	oron-ry V	Link 1	0	Onset and Death				
68760, ficete be executed physician end ss the bunel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	b. ————————————————————————————————————	s a consequence of):	1 1 1 1							
			s e consequence of):								
Box seth cert attendin for use		d									
The de she she she she she she she she she sh	Part II. Other significant conditions co	ntributing to death but not result	ing in the underlying cause g	iven in Part I.			to the cause of death?				
thet the company the detection detection.	Dementer				1 🗆 Yes	2 ml No 3 Pro	obably 4 🗆 Unknow				
Division of Vital Records, P.O. Box (or attending Physician: The law requires that the death certificate death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be deteched for use equilibration: To Be Completed by Divisional					24a. Was an aut performed?	av co	Vere autopsy findings vailable prior to ompletion of cause f death?				
Rec					1 Yes	CONTRACT CON	☐ Yes 2☐ No				
/ital				26. Place of Death /	Check only one)						
ysick hysick li direc	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpetient 3□ DOA	ther: 4 Nursing Home	5 Residence	6 □Other (Speci	ify)				
ion o rding Ph sth. :: After th e funeral		28e. Dete of Injury (Month, Dey Year)	8b. Time of 28c. Injury Wo	uryat 28 ork? ]Yes 2 □No	d. Describe how inj	jury occurred					
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours efter deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28	f. Location (Street a City or Town, Sta	and Number or Rui ate)	ral Route Number,				
ne Hospitu n 24 hours ne Funera pletely fille	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examinetic and manner steted.	edge, death occurred at the t n end/or investigation, in my	time, date and place, en opinion, death occurred	d due to the cause( at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)				
To th To th comp	29b. Signature and title of certifier			se number		Date signed (Month)					
13	mul 1.	m_/	03	(00	<b>.</b>	/21/6	4				
V	30. Name end address of person who c	ompleted cause of deeth (Item 2	Bruinzes	Conta l	8.4 R	Perstant	lang ml				
State	31. Dete filed (Month, Day, Year) MAY 2. 7 2004	32. Registrer's Signatu	to Sporks				V// /				

DHMH 16 Rev 6/95

		1	_ FOr	artment of Health and Me	Reg. N	2001.	16906			
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month  D	oo4 Year	3. Time of Death 7:44 pm			
	/Medic	al -	Dorothy Barbara Dreyfus  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	7.11 P			
	Examin	er	8027 Wynbrook Rd.	Eastpoint		Baltimore	e			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		B. Date of Birth	9. Birthp	lace (State or Foreign try)			
	Director		218-42-3598 1□M 2☒F 59 Yrs.	Worters Days Frours With.	Month, Day, Year Aug. 23,	1944 <sub>M</sub>	_			
	and	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or towns or to	ocation		1	Od. Inside City Limits			
	Maryl -f sho	to	Md. Baltimore East	point			1 ☐ Yes 2 No			
	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cour	try?			
	23e c	alD	8027 Wynbrook Rd.	21224		USA				
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28a-f show eny injury or other treumatic event. The Medical Examiner must be intiffed at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri  1 ☐ Yes 2 ☒ No Specify:	ify Yes or No- ican, etc.)	Yes or No- n, etc.)  14. Race - American I Black, White, etc. Specify: White				
21215-0036	thin 72 hou e. en "nature Medical E	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Ind	dustry			
21	ygien ygien her th		12 /201	ousewife	(First Middle Maid	Home				
Maryland	ntal H ed oth	Be	17. Father's Name (First, Middle, Last)  James Layte		Mother's Name <i>(First, Middle, Maiden Sumame)</i> Dorothy Yanish					
2	should be fand Mental I s marked o	은		ling Address (Street and Number or Rural	Route Number, City	y or Town, State, Zip	Code)			
E S	nd 2 salth ar 27 is r treu		Milton F. Dreyfus husband 80	27 Wynbrook Rd. East	tpoint Md	. 21224				
Baltimore,	Pages 1 annent of Heren ont: If item		'4 Donation 5 Other (Specify)	position (Name of permatory or other place) May 27 200	7, 04 B	Location · City or To altimore	wn, State			
Balt	permit. Departr Importe eny inj		the Enton	22. Name and Address of Facility Connelly Funeral Hor 7110 Sollers point I	Ra. ZIZZZ	dalk				
	Physician		23a. Part 1 Enter the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition		respiratory arrest,		Approximate Interval Between Onset and Death			
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Venticular T  Due to (or as a consequence of):  b. Do O O O  Lusto (or as a consequence of):	i de la companya de l						
	Examiner	<u>.</u>	Sequentially list conditions, b. Coronary quarter off:	rtery disease			6 months			
	rted	Examiner	Cause (Disease or injury	1						
Ć.	ate be executed hysician and the burial-transit	Exal	that initiated events c.  The sulting in death) Last Due to (or as a consequence of):							
3760,	ite be iysicia ne bur	ical	d							
39	artifica ing ph e as th	Med	IF FEMALE:				W=9			
.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	23b. Was decedent pregnant  1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ory Day Year			
٥.	res that the igned by th be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	ne cause of death?			
ds	requires seen sign hould be	d by			1 🗆 Yes	2 ☐ No 3 ☐ Prot	ably 4 Unknown			
Record	e law has t	Completed			24a. Was an autopsy performed	prior to co death?	psy findings available impletion of cause of 2 No			
Vital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		a little on the little of			
of V	S S	ို	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			6 Other (Special	ý)			
o uc		lon:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)		8d. Describe how in	ijury occurred	1			
Division	or Attending after death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined country. At home, farm.			and Number or Rura	M Route Number,			
Ω	2 5 5 6	Certification:	4 Homicide Getermined building, etc. (Specify)		City or Town, St	ate)				
	To the Hospitel or Attenwithin 24 hours after deat Vibration 25 to the Funeral Director: completely filled in by the	ledical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  A manner stated.	ath occurred at the time, date and place, at investigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as s and place, and due t	tated. the cause(s)			
	To th withir To th comp	Me	29b. Signature and the of certifier	29c. License number	29d. I	Date signed (Month,	Day, Year)			
	$\wedge$		> WHIMMING	050595	Me	my 26, 2	004			
-	' '		30. Name and address orgerson who completed cause of death (Item 23a) (Typ Daniel Judge MID, Johns Hopkins Hosp;	tal boo North Wolfes	Street, Bo	16more				
•	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 2 7 2004  37 Registrar's Signature	rente						

		i icase i	State of Marylan	d./ Departme	ent of H	ealth and I	Mental Hygien	e o o o	
	1	= For Amend Item #10° p	er 11 6831 5/27/0	Certifica	ate of L	Death	Reg. No	2004	1690
		1. Decedent's Name (First, Middle, Last)					2, Date of Death Month Da	av Year	3. Time of Death
Physicia /Medic		Edward Leu	viz DeShir	elds			May 18	2004	10:12 PN
Examine		4a. Facility Name (If not institution, give s		4b. Ci		Location of Death		c. County of Deat	
		Holy Cross				Sprix		Montgu	
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday) If Und Yrs. Month	der 1 Year is Days	If Under 24 Hrs. Hours Min.	(Month Day Year	9. Bin	thptace (9tate or Foreig
rector	-	Usual Residence of Decedent		1 113.			March 17, 19	165	r A
Mo M	_ H	10a. State 10b. County	10c. City	y, Town or Location					10d. Inside City Limits
nd other than "natural", or itams 23a or 28a-f show event, the Missisal Exemples must be exhibited at	to	MD Anontag		Baltimore	_	Silver S	Spring		1 ☐ Yes 2 ☐ No
2 7 28 E D.C.	Funeral Director	10e. Street and Number			Zip Code		10g. C	itizen of What Co	ountry?
d la	ai	13202 Strav	insky Tevi	rance	20	2904		USA	
a di	nuel	Tr. Maria	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was De	cedent of Hi pecify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
5	by Fi	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No	Specify:		Specity: 3	lack
al Ex		15. Decedent's Educ		16a. Decedent's U	sual Occupa	ation	16b. I	Kind of Business	/industry
Sign	Completed	(Specify only highest grade	completed)	(Give kind of life. DO NO)	work done o	turing most of wor	king		
3	E	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	Mail 1	Loom	Super	roer	Food	+ Drug Adr
vent, the Ma	Bec	17. Father's Name (First, Middle, Last)	^				ne (First, Middle, Maide		
tic	To E	Thomas Deshir	ild, Jn.			909	17th Saun	illens	
7 is marke traumatic		19a. Informant's Name/Relationship (Ty)	•				ral Route Number, City	-	
item 27 other tr		Judith A-Green		13202	Stra	vinsky T.	evenue Si	Ive-Spran	11, MD 2090
or off		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ R	emoval from State	Place of Disposition (formatory of	or other plac			Location - City or	
4 5		' 4 □ Donation 5 □ Other (Specify)		Media Ca	emente	may?		Media	
Importa any inju once.		21. Signature of uneral ervice Licen		22. Name	and Addres	Lose Full	rend Sen	ice, P.A.	Sind King
= 4 Q	$\rightarrow$	23a. Part1. Enter the disease, or compli	that arread the death					e mo	Approximate
		shock, or heart failure. List only or	e cause on each line.				4		Interval Between Onset and Death
ician		Immediate Cause (Final disease or condition resulting in death)	l		1 VOice	CA	nrhy thmice		minutes
dical niner			Due to (or as a consequence	juence of):	1 (	ه معدالا، هم، ،	opathy		1100
	iner	Sequentially tist conditions, if any, leading to immediate	Due to (or as a consequ	ruence of):	) (	VUIUN	roparny		years
ansit		cause. Enter Underlying Cause (Disease or injury that initiated events					<b>V</b>		
rial-tr	Exami	resulting in death) Last	Due to (or as a consequ	uence of):					
ne bui	Cai		l						
attending physician and for use as the burial-transit	Medi	IF FEMALE:							
r use	Physician/M	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		pregnancy			23d. Date of de Month	otivery Day Year
tached fo	sic	in the past 12 months?  1 Yes 2 No	4 Pregnant at time of de 9 Unknown	death 5 ☐ Other	(specify)			Worth	Day Tour
detact	Phy	9 ☐ Unknown  Part II. Other significant conditions cor	atributing to death but not rec	uilting in the underlyin	a called also	on in Dart I	23e Did tobacco	use contribute t	o the cause of death?
99	by	() besit	•	suiting in the underlyin	g cause give	9(1 k) F 0(1( 1,			robably 4 Dunknow
Should	Completed	000511	<del>)</del>			-			105g12 x212 315
9 2	mpi						24a. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
ctor, page							1□ Yes 250 N		s 2 No
S ĕ	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 🍒	LER/Outpatient 3	DOA Othe	ar	ath (Check only one)  Iome 5 Residence	6 MOther (See	20(64)
r this aral di		1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun	/ at	28d. Describe how int		ychy)
: After	tior	1 Natural 5 Pending investigation	(Month, Day Year)	Injury M	Worl	k? Yes 2 □ No	1		
d in by the f	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, street, fac	tory, office		28f. Location (Street a City or Town, Sta		lural Route Number,
i D	Certification;	4 Notticide	building, etc. (Specif	(4)			ony or rown, one	10)	
completely filled in by			sician: To the best of my kno ner: On the basis of examina						
plete	Medical	one)	and manner stated.						
COUL	Σ	29b. Signature and title of certifier			29c. Licensi		29d. D	ate signed (Moni	
		low are spa	uspmo		Do	05/670		5/19/	oy
		30. Name and address of person who co	empleted cause of death (Item	m 23a) (Type, Print)	11) (		treet Suit	. 70/2	Class.
		Towendy S	prug 95, MI	) 140	NA	virg >7	meet suit	e cou :	>11vagarily 1
Sta Registr		Towendy S  31. Date (iled (Month, Day, Year) MAY 2 7 2004	132. Registrar's Signar	ature Ana H	10 Sp	virg Sy	freet Suit	e 200 S	Silverpul

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01,38 AM NELAWDER BUNDA 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD GENERAL COLUMBIA HOWARD County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1 M 2 XF Days Hours 59 216-48-7853 March 8, 1945 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 1 Yes 2 No Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 U.S.A. 4740 Woodland Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□Yes 2DNo White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) homemaker lunk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Woodrow Wilson Scott Gladys Blackburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4740 Woodland Rd. Ellicott City, Maryland 21042 Mr. Edward Delwader Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 1 Burial 2 Uremanon 4 Donation 5 Other (Specify) 05/29/2004 Lisbon, Maryland True Gospel Cemetery 22. Name and Address of Facility
Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Usist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BOWEL ISCHEMIC DAY Due to (or as a consequence of): CARCINOMATOSIS ABDOMINAL 4 YEARS Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? (640) HYPERTE HSICH HYPER-1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

attending physician and tor use as the burial-transit

P.O. Box

Records,

Division of Vital

the Hospitel or Attending Physicien:

To the now, within 24 hours after own To the Funerel Director: A'

permit. Pages 1 and 2 should be like Department of Health and Mental Hy Important: If item 27 is marked oth any liquy or other treumatic event size.

Baltimore, Maryland 21215-0036

10

General

**Physician** 

/Medical

Examiner

**Funeral** 

Director

123a or 28e-f show

Director

Be Completed by Funeral

၉

Examiner

Physician/Medical

Completed by

Certification;

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

28a. Date of Injury (Month, Day Year)

LI DIDEMIA

24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical Hospital: 1 Inpatient

28b. Time of

2 X ER/Outpatient 3 DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 6 Could not be determined

28c. Injury at Work? 1 ☐ Yes 2 ☐ No М 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of perfifier

29c. License number 138296

29d. Date signed (Month, Day, Year)

SLLICOTT CITY MD 21042

30. Name and advirest of person who completed cause of death (Item 23a) (Type, Print)

mo

JOSEPH F. G. B. 3 ONS MD 9501 OLD ANNAPOLIS AD SKITE 202,

State Registrar

31. Date filed (Month, Day, Year) MAY 2 7 2004 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For the Registrar AMPND TIPM #23b PPR PHY C831 5/27/64 effificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Catherine Jean Dickel 3 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Worchester Berlin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛣 F 219-28-9898 Yrs. Director 71 Oct. 23, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f ehow event, the Medical Examinar must be notified at Maryland Worchester Ocean City 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Sandy Hill Drive 21842 Funeral S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Š Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname, permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 Is marked ot any injury or other traumatic even 1 and 2 should be 1 Health and Mental David P. Sullivan, Sr. Lillian C. Junker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Dickel, son 4506 John Street Halethorpe, MD. 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 05-19-04 Brooklyn Park, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. ce hours 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 Ø No Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2.☑ No Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ŏ After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) phy516/1) 30. Name\_and address of person who completed cause of death (Item 23a) (Type, Print) Durley 9733 HC4/tha 31. Date tiled Month, Day, 22 Bagistrar's Signature State Registrar

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	/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death				
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	Funeral			s. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign			
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	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director, is	Med	29b. Signature and title of certifier		29c. License number	29d	Date signed (Month,	Day, Year)			
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	[0		30. Name and address of person who completed cause of death (It	em 23a) (Type,	Print), of Maryland - s	ho, KT	Thum. C.	ntem			
	CA.	10	31. Date filed (Month, Day, Year) 32. Registrar's Sig				-0-00	-1100			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 3 per Shate 088M 95/27/04/dbb partment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:21p Holtzclaw Fetherston, Jr. 2004 May 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8820 Walther Blvd., #2106 Parkville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Director 137-26-3933 74 July 21, 1929 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a 8820 Walther Blvd., #2106 21234 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1953-55 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene important: if item 27 is marked other tha any injury or other treumatic event, that once. 12 04 Proprietor Hardware Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holtzclaw Fetherston, Sr. Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence E. McKinley/Nephew 12158 Holly Knoll Circle, Great Falls, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 27, 2004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. Timonium, Maryland 2) Signature of Funeral Service Lice P. Name and Address of Facility
Demmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clar 23a. Part 1. Enter the disease, or complications that caus shock, or heart ailure. List only one cause in each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Enysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No ospitat or Attending Physician: Thours effer death.
unerel Director: After this certificatifilled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours e To the Funerei C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier May 26, 2004 30. Name, nd address o person who completed cause of death (Item 23a) (Type, Print) 10+1 Iredele Iglehart, III, M.D. 6301 N. Charles St., suite 5, Baltimore, MD 21212 MAY 2 7 2004 32 Registrar's Signature State Spark Registrar

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			30. Name and address of personal TACK M. To	tus, M.D	se of death (Ite	m 23a) (Type	11 Print)	1 Pe	enn St	reet,	, Balt	imor	e, Mary	land	21201	
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			For State Registrar	State of I	Maryland /		rtment of H		Mental Hy	giene 2 0	04	16913
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	Director		218-32-1752	<b>⊠</b> M 2□F	95	Yrs.	Months Days	Hours Min.	(Month, D Aug. 10		Countr Mar	ace (State or Foreign y) cyland
	ryland how		10a. State 10b. County		10c. City, Tov	wn or Lo	ation				100	d. Inside City Limits
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	ms 2;	era	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or N		e - Americai	
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∤ 215-0036	72 hou natura	eted	15. Decedent's Ed (Specify only highest gra	l ducation		Deced	ent's Usual Occupa	ation during most of wor	kina	16b. Kind of B	usiness/Indu	ıstry
2121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)	`life. [	wind of work done of the NOT use retired.	)		Supply	Compo	
Q 6	filed Hygi othar ant, I	Be Co	17. Father's Name (First, Middle, Last)				Owier	18. Mother's Nan	ne (First, Middle	, Maiden Suman		шу
Naryland 21	ould be Mental Markad	ToB	Clarence	Fost				Emma		Bowers		
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship ( David Foster/son				g Address <i>(Str</i> eet a <b>thoridge</b>				State, Zip C 21 09	
ore,	of Health of Health if item 27 or other tr		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from Sta	20b. Place o	of Dispos ery, crem	sition (Name of patory or other place	θ)	Date	20c. Location -	City or Tow	n, State
Lock Baltimore	permit. Pages Department of I Important: if Its any injury or or once.		4 Donation 5 Dother (Specif	y)	Jesso		metery		8/2004			ryland
The Bar	permit. Departn Importe any inju		21. Signatur Fundal Service Lice	S	. Coster		Name and Addres	,				Home, Inc. 204
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	line.		r the mode of dying	g, such as cardiac	or respiratory a	arrest,	1 1	Approximate nterval 8etween Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a CAr	Dio Ulmo	<u> </u>	AMIRST				-	
AL.	Examiner		Sequentially list conditions	b. 50	bais							
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	a a consequence							
0	ate be executed thysician and the burial-transit		that initiated events resulting in death) Last	U	as a consequence							
876	cate be ohysici the bu	dicai	(	d								
Box 68760,	Jeath certifica attending ph	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	e of delivery	
P.O. B	he death r the atte ched for	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death at time of death		Ectopic pregnancy Other (specify)			Mo	nth D	ay Year
S, P.	res that the de igned by the a be detached	by Ph	Part II. Other significant conditions of	ontributing to death	but not resulting	in the un	derlying cause give	en in Part I.	23e. Did	tobacco use cont	ribute to the	cause of death?
ord	w require been signshould t						<u></u>					oly 4 Munknown
Division of Vital Records,	2 2 2	Completed							24a. Was auto perf	ormed?	leath?	sy findings available oletion of cause of
Vita	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner?	Hospital:	0F500		Othe	26. Place of Dea				
101	ding Phys h. After this funeral di	$\vdash$	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 ☑ Inpa 28a. Date of In (Month, I		Time of Injury	3 DOA 28c. Injury Work	at A □ Nursing H		idence 6 ∐Oth how injury occuri		b.
sion	eath. or: Aft	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1	Jay 1 ear)	irijury		r res 2 □ No				·
Divi	al or Atten s after deat il Diractor: id in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	288. Place of	Injury - At home, fa etc. <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location ( City or To	(Street and Numb wn, State)	er or Rural F	Route Number,
	To the Hospital within 24 hours of To the Funaral I completely filled	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basis and manner	of examination ar	e, death	occurred at the time estigation, in my op	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma date and place,	nner as state and due to th	ed. ne cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	7			29c. License	number		29d. Date signed	(Month, Da	ay, Year)
	/		1	12	•			44018		05	25/0	4.
	15		30. Name and address of person who	Annouse o				nth choi	PIST.	SUITE 200	3 Boc	mase no
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 7 2004	32. Regi	strar's Signature	200	d					7120y
	negisti	ul	III A ( 2004	JANES SEL	10. Mg							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 21. **Physician** Stephen Stanley Flessner 2004 13:54 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7312 Conley Street Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 02/12/1921 7. Age (In vrs. last birthday) Birthplace (Stete or Foreign
Country) **Funeral** XXM 2□F 83 216 12 0951 Director Maryl and Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28e-f ehow the Wedical Examiner must be notified at Baltimore MD Dundalk 1 ☐ Yes 🏋 🗓 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7312 Conley Street USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 Is marked other than "natural", or Ite 1 ☑ Yes 2 □ No If Yes, Give ↓ WII Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHite þ 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filled v Department of Health and Mental Hygien Importent: If item 27 is marked other th eny injury or other traumatic event, IIIA 2002. Post Office Letter Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stephen Flessner Juliana Sypniewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8312 Conley Street Dundalk Maryland 21224 Geraldine D Ortel Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition KXBunal 2 Cremation 3 Removal from State 5/25/2004 Oaklawn Cemetery 4 □Donation 5 □ Other (Specify) Eastwood. MD. 21. Signature of Juneral Service License <sup>22. Name and Address of Facility</sup> Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 2123/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No page 2 should be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) atternasio MO D-28097 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1576 Merntt, Blud.; Sute # 14 Balt, more, Md. 21222 MASIO

DHMH 17 Rev 1/2001

State Registrar 32, Peoistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [, 1 = For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death a Say **Physician** Doris Elizabeth France 0008 Mai 2004 /Medical 4c. County of Death Harford 4a. Facility Name (If not institution, give street and number)
Upper Chesapeake Medical Ctr. 4b. City, Town, or Location of Death Bel Air Examiner 7. Age (In yrs. last birthday) 87 yrs 8. Date of Birth (Month, Day, Year) 11/14/1916 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 215 07 9871 Director Maryland Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28e-f show Examiner must be notified at Rosedale Balitmore MD 1 □Yes XX No Director 10f. Zip Code 21237 10g. Citizen of What Country? 10e. Street and Number USA 7914 Elmhurst Ave Funeral Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. should be filed within 72 hours after ond Mental Hygiene marked other than "natural", or Iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Hohman Harry Doering 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
837 Seneck Park Rd Middle River Maryland 21220 19a. Informant's Name/Relationship (Type, Print) SON Bernard Wagener Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/28/2004 Raspeburg, MD. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 160 Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to attending physician and for use as the burial-transit dì Due to (or as a consequence of Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) \_ o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by tailus 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an autopsy performed? 3 Division of Vital Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2€ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 25,200 Way

Registrar

31. Date filed (Month, Day, Year)

MAY 2 7 2004

40/50/

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 5,7,8,10f,19b per FH,631,05/27/04dhb

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last, Physician 2:20 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, gi **Examiner** N/AMore 10/04/1972Birthplace (State or Foreign 8. Date of Birth Month, Day, Year If Under In vrs. last birthday **Funeral** Spain Spain Days Hours 1**X** M 2 □ F 31 302-04-1780 Director Usual Residence of Decedent 10d. Inside City Limits the Manyland 10c. City, Town or Location 10a. State 10b. County t of Health and Mental Hygiene.
If Itam 27 is marked other than "natural" or Itams 23a or 28a-f show or other traumatic event; If a Medical Examinar must be inclined at 1 ☐Yes 2X No N/A Castilla-Leon by Funeral Director Salamanca 10f. Zip Code UNK 10g. Citizen of What Country? 10e. Street and Number Paseo de San Vicente, 10 4A 37007 Spain Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Never Married 2 Married 1 X Yes 2 No Specify: Spanish Specify: Spaniard Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College 5+ Professor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rodolfo Vidal-Herrero Sagrario Gonzalez-Diaz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 37007 Paseo de San Vicente, 10 4A Salamanca Spain Rodolfo Vidal-Herrero/father 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ Department of Important: If any njury or Metro Crematory, Inc. ` 4 ☐ Donation 5 ☐ Other (Specify) 5/27/04 Baltimore, MD 21. Signature of Funeral Chemation Society of Maryland, Inc. Service License DIMME McDonald Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician 170 /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, any, leading to in recliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ ed bluods 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital Hospital or Attanding Physician: 24 hours after death. Funaral Director: After this certifica 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Be Hospital: Other: 1 Inpatient 4 ☐ Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ပ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day) 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: Iniun 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 ☐ Could not be Rural Route Number, determined 4 Homicide Pelmey Vallenko AND JAPRET within 24 hours a To the Funeral L Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature 🛶 😁

Registrar

State

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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			1 _ State	· ·	Certificate of Death		2001	
			Registrar  1. Decedent's Name (First, Middle, Last)		Definicate of Death	2. Date of Death	. No. 2004	3 time of Peath 7
	Physici	an			GILES	Month	Day Year	8:49 PM
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	JULY ?	4c. County of Death	
4	Exami	iei		HOSPITAL	RANDALLSTOW	4	BACTIMO	RE
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last birth	day) If Under 1 Year   If Under 24 Hrs			ace (State or Foreign
	Director		154-42-8106	1M 2XF 54 Y	rs. Months Days Hours Min.	MAY 26.1	949 PENNS	SYLVANIA
	D .		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Logation			
	shov	5	Toa. State Tob., County	/ o		- 0	,	d. Inside City Limits 1     Yes 2   No
	28a-f	Director	MARYLAND  10e. Street and Number	A	10f. Zip Code		. Citizen of What Count	- 1
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show the Modical Examirer must be notified at	급		100 11/2 11/2	101. 21p Code	2	. Citizen of what Count	ry r
	eath	Funerai	5206 MIDWO	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - America	n Indian.
10	r Ren	Fun	Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	o Rican, etc.)	Black, White, e	
036	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BL	ACK
215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. [	Decedent's Usual Occupation	king 16	b. Kind of Business/Indu	ustry
21	within ene.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of wo life. DO NOT use retired)		. 1	
21	filed wi Hygien other th	Con	12 HIGRADE		SISTANT NUR		VURSING	
nd	ould be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, Last)	UNKNOWN)	18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)(UN)	(NOWN)
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene.  If item 27 le marked other then "neturel", or Items 23a or 28a-f show or other treumatic event. If a Michigal Examiner must be notified at	မ						
Mai	12 shound hand 7 le m		19a. Informant's Name/Relationship (Ty	pe, Print) 190.	Mailing Address (Street and Number or Re	iral Houte Number, C	ity or Town, State, Zip (	Code)
_	1 and Health em 27 ther tr		JOHN WARREN  20a. Method of Disposition	20b. Place of I	Disposition (Name of	Date 20	c. Location - City or Tow	of L/ol
Jon	Pages nent of int: If it		1 ☐ Burial Cremation 3 ☐ F	emoval from State cemetery	crematory or other place)	12 111 0	34.	- 7400 9740 0800 0800 080
Baltimore,			<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funer I Service Cons.</li> </ul>	METR	CREMATORY 05-3	21-09/	PALTIMORE	MAKYLAND
Ba	permit. Departr Importa			(m)	JOSEPH IT. K	ROWN	R. FUNERA	LHOME
	_		23a. Part1. Enter the disease, or compl	cations that caused the death. Do no	ot enter the mode of dying, such as cardian	or respiratory arrest	17210:190	Approximate
	Pnysician		Immediate Cause (Final	CERVICAL				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of	):			
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9 X	ding I	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy			004 Data of dellar	
Вох	atten for u	cian	in the past 12 months?	1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month	y Day Year
o.	the d y the	Physician/Med	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9☐ Unknown				
٩	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	by PI	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	cause of death?
Records,	quires n sign uld be	q pe		V 100		1 🗆 Yes	2 □ No 3 □ Proba	bly 4 Nknown
00	s been si s should I	olete				24a. Was an	24b. Were autops	sy findings available
Re	The late ha	Completed				autopsy performe 1 Yes 2	d? death?	pletion of cause of
Vital		0	25. Was case referred to medical		26. Place of Dea	ith (Check only one)	1 1 1 1 1 1 2 1 1 3 2 2 1 1 1 1 1 1 1 1	
f V	> 50	To B	examiner? 1 Tes 2 No	lospital: 1 Inpatient 2 ☐ ER/Outp	patient 3 DOA Other: 4 Nursing H	ome 5 Residence	æ 6 □Other (Specify)	
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury 28b. Tin (Month, Day Year) Inj	me of 28c. Injury at work?	28d. Describe how	injury occurred	
Sio	Attending Ph death. ctor: After th y the funeral	atle	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	l or Attendater death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural i State)	Route Number,
	urs al							
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier 1/A Certifying Physical Check only one) 2 Medical Exemi	ner: On the basis of examination and	death occurred at the time, date and place of investigation, in my opinion, death occurrence.	, and due to the caus rred at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)
	thin 2 the outple	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	. Date signed (Month, D	av. Year)
	F 3 F 8			MD	057722	/	VAV 2. 2	1714
7	1		30. Name and address of person who co				"1 21 2	
	1		WONARD RICHARDSO	N 5401 OLD COU	RT RUAD RANDAUS	TOWN M	P 21133	
	Sta	ate	31. Date filed (Month. Dav. Year)	22. Registrar's Signature	/	100/0	11 21	
	Registi		MAY 2 7 2004	Denve &	Dock			

			For State Registrar	State of M	faryland / De	partmen <i>ertificat</i>			d Mental Hy	giene Reg. No. 2	104 1691	8
	°Physicia	an	1. Decedent's Name (First, Middle, Last)		Cillogn	io			2. Date of D Month	Day	Year 3. Time of Deat	
	/Medic	al	4a. Facility Name (If not institution, give		Gillesp		Town, or	Location of De	MAY	26 5 4c. County	Lec4 3.40 A	
	Examin	er	ST. AGNES HEALTH		,			MORE			TIMORE .	
	, Funeral		5. Social Security Number 6. Sec	7. A	Age (In yrs. last birthd	Months	1 Year Days		in (Month D	irth	Birthplace (State or Fore Country)	eign
	Director		223-22-3040 123 Usual Residence of Decedent		81 Yrs				11-1	4-1922	Virginia	
	yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Lim	nits
	e Mar Be-fat	ctor	MD Howard	Į .	Elli	cott (	City	•			1 □ Yes 2 <b>X</b>	No
	with th	Director	10e. Street and Number	J V.T	I - D	10f. Zip		4.2		10g. Citizen of		
	eath v	Funeral	3244 Apt B Norm	12. Was Deceder		3. Was Dece	210 dent of Hi		(Specify Yes or N		ed States	
9	after d or Item niner		1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 ☐					(Specify Yes or N lerto Rican, etc.)	Bla	ck, White, etc.	
03	ours a	d by	3 ☐XVidowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 🗆 Yes				Specif	White	
15-(	within 72 hours after death with the Maryland one. than "netural" or Items 23s or 28e-f ahow the Marical Examiner must be natified at	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(G	cedent's Usu- ive kind of wo e. DO NOT u	al Occupa rk done d se retired	ation fu <i>ring m</i> ost of ( ')	working	16b. Kind of B	usiness/Industry	
72	y withii jiene. r then	omp	Elementary/Secondary (0-12)	College (1-4o	r5+) Hear				perator	Const	ruction	
ğ	al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)				•		Name (First, Middle			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If Health and Mental Hygiene. If the alth and Mental Hygiene. other is marked other than "netural", or Items 23s or 28e-f show other traumatic event, the Medical Examiner must be neitified at	To	Harry Walter Gi						Bowman			
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty Brenda Sue Tuck		7	-			Rural Route Numi	-		12
9	tem 2		20a. Method of Disposition	CI/ Baa	20b. Place of Di	sposition (Na	ne of	!	Date		- City or Town, State	12
altimore.	Pages nent of h int: If its		1 ☐ Burial 2 【★Cremation 3 ☐ P `4 ☐ Donation 5 ☐ Other (Specify)	temoval from Stat	Metro	crematory or d Crema			26-2004	Caton	sville, MD	
Balti	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service License	- hall	01044	22. Name ar	nd Addres	s of Facility Ha	arry H.	Witzke Ellic	e's Family E	FH MD
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caus	ed the death. Do not						Approximate Interval Between	
	Priysician		Immediate Cause (Final disease or condition	ACUT	E MYOCA	2DIAC	IN	FARETI	10N-		Onset and Death	-
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of):						·	
	13	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of):							
	cuted	Examine	that initiated events	3								
/× 0	sate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a	is a consequence of):							
3/8760	icate b physic s the b	dica		d								
Box 6	eath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcon		- 6-				23d. Da	ite of delivery	
, o	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		at time of death	3 □Ectopic p. 5 □ Other (sp				М	onth Day Year	
Ad	res that the de		Part II. Other significant conditions con	ntributing to death	but not resulting in th	e underlying o	ause give	en in Part I.	23e. Did	tobacco use con	tribute to the cause of death?	?
EDWAR.	w requires been sign should be	Completed by	LARYNGEAL C	ARCINO	MA-				112	Yes 2□No	3 Probably 4 Nunkno	)WN
SK OS	law re as be	plet	LUNG CARCII	VOMA.					24a. Wa auto	s an 24b.	Were autopsy findings availa prior to completion of cause	ible of
I E	sician: The law certificate has t lirector. page 2 s	Con								ormed?	death? 1 ☐ Yes 2 ☐ No	
Vital	Physician: this certific ral director.	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpa	tient 2 ☐ ER/Outpa		Othe	2.00	Death (Check only		(0,000)	
PIE	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Ir (Month, L		e of	8c. Injury Work	at	g Home 5 Res 28d. Describe	how injury occur		
S io	Attending Ir death.	atlo	1 ☑ Natural 5 ☐ Pending investigation	(Morter), L	ray rour) mga	М		Yes 2 □ No				
12 LES F Division	al or Att after de Directe d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	njury - At home, farm, etc. <i>(Specify)</i>	street, factor	, office			(Street and Numb own, State)	per or Rural Route Number,	
61	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director. page	Medical C			st of my knowledge, d of examination and/o stated.						anner as stated. and due to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	P			c. License				d (Month, Day, Year)	
			> May hothe				P17	608.		5/26	104.	
	/		30. Name and address of person who co				BALT	TIMORE	, MD a	1229.		
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 7 2004	32, Regis	strar's Signature	Son	ر پھو	,	, MD a			

DHMH 17 Rev 1/2001

ı			1 - For State Registrar		State	of Mary	land / Depa <i>Ce</i>	artment of I rtificate of	lealth a <i>Death</i>	nd Menta		ene 2 (	004	16919
	Physici /Medi		1. Decedent's Name (First, Justin Lee							Mo	te of Death onth Y 21,	Day 2004	Year	3. Time of Death 8:10 P M
	Examir		4a. Facility Name (If not ins HARBOR HOSP.	ITAL				4b. City, Town, o	ORE CI	TY		4c. County	of Death	
	Funeral Director		5. Social Security Number  219-33-1910  Usual Residence of Decede		Sex 1☐√M 2☐ F	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (M	te of Birth onth, Day, Y y 6 19		9. Birthp Court Md	place (State or Foreign ntry)
	Maryland I-f show	tor	10a. State 10b. C			1	e. City, Town or Low Westmins						1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23a or 28e	<b>Funeral Director</b>	10e. Street and Number 291 Pleasar	nt Va	11ey Ro	ad		10f. Zip Code 2115	58		10g	. Citizen of	What Coun	ntry?
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 Is marked other than "netural", or items 23a or 28a-f show or other traumatic event, the Mudical Evarities must be routiled at	by	11. Marital Status  1 XNever Married 2  3 Widowed 4 Div		12. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	orces? 2 GNo ive X		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ∏ No	lispanic Orig an, Mexican, Specify:	in? (Specify Ye Puerto Rican,		14. Rad Blad	ce - Americ ck, White, v: Whit	etc.
21215-0	within 72 ho ene. than "netur to Medical	Completed	15. Dec (Specify only) Elementary/Secondary (C 1 2		ade completed	(1-4or 5+)	lite.	dent's Usual Occup kind of work done DO NOT use retired 10USE WOY	during most ( d)	of working		b. Kind of Bi		•
Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Its M.	To Be Co	17. Father's Name (First, M Michael Ray						18. Mother	's Nam <i>e (Fir</i> st, sa Marl			*	
	1 and 2 sho Health and em 27 ls ma ither trauma		19a. Informant's Name/Rela				291 H	ng Address (Street Pleasant						
Baltimore,	Pa Int		20a. Method of Disposition 1	ation 3 [ ner <i>(Specii</i>	□Removal from fy)	State	Crest Law	natory`or other plac In Memori	al 5-	Date -26-04	Ma	c. Location -	tsvi1	le. Md
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Se	na	. Has	set		O. Box 1	95 Syk	esville	∍, Md	21784	me &	Chapel
	Pnysician /Medical Examiner		23a. Par1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ſ	plications that one cause on	ingi	death. Do not ent	er the mode of dyir	ng, such as ca	ardiac or respi	ratory arrest,			Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Linears of July that initiated events resulting in death) Last	1	С.		sequence of):							
.O. Box	death cert e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 ∐I nant at tim <i>e</i>	Fetal death 3	Ectopic pregnancy Other (specify)				23d. Dat Mor	e of deliver	ry Day Year
rds, P	w requires tha been signed I should be det	by	Part II. Other significant co	nditions o	contributing to c	leath but not	resulting in the ur	nderlying cause giv	en in Part I.	23	e. Did tobace	- /		e cause of death?
al Record	The farate has	Completed									a. Was an autopsy performed	1?	rior to com leath?	sy findings available apletion of cause of
sion of Vital	Attending Physicien: The redeath. ector: Atter this certificate by the funeral director, pag	ation; To Be	2 ☐ Accident in	ending Ivestigation	28a. Date (Mon	of Injury th, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injun Worl	er: 4 □ Nurs y at				ed	D self
Division	= i= c	l Certification:	4 ☐ Homicide d	ould not b	build	ing, etc. (Sp	POU	K		3698	Home S	tate) - h	lis	Route Number,
	To the Hospital of within 24 hours af To the Funerel D completely filled in	Medical	29a. Certifier 1 ☐ Certifier (Check only one)  27 Mer  29b. Signature and title of certifier of certifier (Check only one)	dical Exar	niner: On the b	asis of exan	nination and/or inv	occurred at the tin estigation, in my of	pinion, death	occurred at the	e time, date	and place, a	and due to	the cause(s)
	\rangle \rang		30 Name and address of pe	: ar	onica	-Pol	Ohn	0	C M E			AY 22,		•
	Sta	te	31. Date filed (Month, Day,	Aro	- AUILY	Registrar's Si	KNO		Penn S	treet,	Baltir	more,	Mary]	land 21201
Ne.	Registr		MAY 2 7	200/		Rusa	4	Soul!	~					

		1	For State Registrar			d / Depa		of H	ealth an	d Mental H	ygien Reg. N	_		
	Physiciar /Medica	1	Decedent's Name (First, Middle, La.     Thomas Will     As. Fecility Name (If not institution, giv.)	iam Hayes			Ah City T	OWN OF	Location of D	Month	Z	•	Deeth	3. Time of Death
	Examine		Carroll Hospital	Center			1	West	minste	er		Ca	rro	
	Funeral Director		101-10-7400	ex 7.7 <b>X</b> M 2□ F	Age (In yrs.	last birthday)	If Under 1 Months	Days	If Under 24 I Hours A	Hrs. 8. Date of B Ain. (Month, 2 Jul 27	ay, Yee, 7,191	13	9. Birthp Coun New	place (Stete or Foreign htry) YORK
	e Maryland ta-f ahow tiffed at		Usuel Residence of Decedent  10a. State     N⊕w     York     Nassa	u	10c. Cit	y, Town or Lo	ocation		Oceans	ide				1 ☐ Yes 2 ☐ No
	h with the 13a or 28	al Dire	10e. Street and Number 425 Bedell Stre	et			10f. Zip (	Code	11572		10g. C	itizen of Wh	nat Cour JSA	itry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other treumatic event, the Madical Examinar rount be notified at once.	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 12 Yes 2 [ If Yes, Give Year or Dates	s? ] No		Was Decede If Yes, specif		ispanic Origin in, Mexican, Pi Specify:	? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race Black, Specify:	White,	
215-0	thin 72 ho e. an "natur Wedical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-40	r 5+)	(Give	DO NOT use	k done d e retired	during most of	working	16b.	Kind of Busi		dustry
ind 21	be filed winter Hygien and other the	e	17. Father's Name (First, Middle, Last, William Hayes	)	7		Law	yer		Name (First, Middle		n Sumame)		
Baltimore, Maryland 21215-0036	od 2 should tth and Mer 27 is merke treumatic	0	19a. Informant's Name/Relationship ( Thomas Hayes, Jr.	**		100			and Number o	or Ryan N r Rural Route Num rive, Har	ber, City	or Town, S		
more,	Pages 1 ar ent of Hea nt: If Item 2 ry or other		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special		ie C	Place of Disponentery, cre	matory or oth	her plac		Dete /25/2004		Location - C	•	
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Lice	1590 MC	123 U	- 2	2. Name and			Eline I St, Hamps				74
9	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Se	1	emia		of dyin	g, such as car	diac or respiratory	arrest,			Approximate Interval Between Onset and Death
8760,	pa pa	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequence									
O. Box 68	w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 Feta	I death 3	□Ectopic pre □ Other (spe					23d. Date Monti		ery Day Year
rds, P.O.	quires that n signed by	ed by Pr	Part II, Other significant conditions	contributing to death	but not res	ulting in the u	underlying ca	use give	en in Part I.					he cause of death?
★ Division of Vital Records,		Completed								24a. Wa aut per 1 □ Yes	opsy formed?	de	ath?	opsy findings available impletion of cause of
Vita	Physician: The this certiticate ral director, pag	Re	25. Was case referred to medical examiner?	Hospital:				Oth	90	Death (Check only				
on of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certilic completely lilled in by the funeral director,	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of I		28b. Time of Injury		Bc. Injun Worl	4 U Nursir	ng Home 5 ☐ Re 28d. Describe			-	у)
Divisi	To the Hospitel or Attending within 24 hours after death. To the Funerel Director. After completely lilled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At h etc. (Special	ome, farm, si	treet, factory,	, office		28f. Location City or T	(Street own, Sta	and Number ite)	or Rura	al Route Number,
	Hospitel     24 hours     Funerel     Ietely tilled	Medical C		hysician: To the be miner: On the basis and manner	s of examina									
	To the twithin 2. To the to the Complet	Me	29b. Signature and title of certifier	Joles					e number 06072	1	29d. C	A Gy		Dey, Year)
_	10		1101101	cón	200 1	Memo		venv	e ives	tministe.	- N	10 21	15	7
	Stat	е	31. Date filed (Month, Day, Year)	Seneral Seneral	strar's Sign	Ture	na V	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Evelyn C. Hewitt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Ipwn, or Location of Death **Examiner** Kosedale auare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9/14/1908 yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 95 Days 1 ☐ M 252 F Mary Land Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show or other traumatic event, the Medical Exertimer must be notified at MD Baltimore Rosedale 1 ☐ Yes 2 X No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7921 33 rd Street 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2XXIII o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏂 No White Specify: Be Completed by 3X Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental George Calvin Fitze Eliza Jane Virginia Zepp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7921 33rd Street Rosedale Maryland 21237 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: If itam 27 la any injury or othar trat QDCS. Darlene Spahn Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem 5/24/2004 Raspeburg MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cvach/Rosedale Funeral Home 21. Signature of Fundral Service Licensee 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Cancer 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 2 No Certification; To 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death
Natural
Control 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Director: A investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

VD

31. Date filed (Month, Day, Year) MAY 2 7 2004

29b. Signature and title of certifier

THOMAS 9000 Franklin Square Dr. Baltimore 32. Registrar's Signature

MO 30. Name and address of person who completed cause of death (Item 23a) (Type\_Print) 00056851

29d. Date signed (Month, Day, Year)

			1 - For Stete Registrar	State of Marylan		artment of tificate of			iene	4 16920
	Physici /Medio		Decedent's Name (First, Middle, Last)     SANTEE HARRISON					2. Date of Dear Month MAY 24		3. Time of Death 3:00 aM
	Examin		4a. Facility Name (If not institution, give s 1300 E LANVALE STR	EET APT 430		4b. City, Town, BALTIMOR If Under 1 Yea		ath	4c. County of Dea	
考	Funeral Director		5. Social Security Number 6. Sex 217 34 0084  Usual Residence of Decedent	N 2015	62 Yrs.	Months Days			, 1941 VIR	thplace (State or Foreign ountry) GINIA
	e Maryland Ba-f show	Director	10a. State 10b. County  MD N/A		y, Town or Loc IMORE					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with th		10e. Street and Number  1300 LANVALE ST A	PT 430		10f. Zip Code 21213			og. Citizen of What Co .S.A	ountry?
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28s-f show aumatic event, the Medical Exacting must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	J1	Vas Decedent of Yes, specify Cu	ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify: BLi	e, etc.
Maryland 21215-0036	filed within 72 ho Hygiene. Ither then "netur ant, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	OO NOT use retir	during most of v		16b. Kind of Business	
/land 2	should be filed ind Mental Hygi is marked other umatic event, it	To Be C	17. Father's Name (First, Middle, Last) SANTEE HARRISON					lame (First, Middle, I	Maiden Sumame)	
altimore, Mary	1 and Health em 27 other tr		19a. Informant's Name/Relationship (Ty.  ANGELA SMITH (Sis  20a. Method of Disposition  1 \( \mathbb{Z}\)Burial 2 \( \mathbb{C}\)Cremation 3 \( \mathbb{R}\)  4 \( \mathbb{Q}\)ponation 5 \( \mathbb{Q}\)Other (Specify)	ter)  20b. P	1110 Mace of Disposemetery, crem		RCLE BAL	TIMORE, M	ARYLAND 21, 20c. Location - City or BALTIMORE	207 Town, State
Baltii	permit. Pages Depertment of Important: If it any injury or o	L	21. Por ature of Funeral Service Licens	V. Sury		Name and Addi	ess of Facility	CALVIN B.	SCRUGGS FU	UNERAL HOME RYLAND 21213
8760,	The law requires that the death certificate be executed  X  X  X  X  X  X  X  X  X  X  X  X  X	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).	uence of):	0 1	vec	ac or respiratory and		Approximate Interval Between Onset and Death
O. Box 6	that the death certificated by the attending placed by the attending placed for use as t	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnan Other (specify)	су		23d. Date of dea Month	ivery Day Year
rds, P.	w requires that is been signed by should be detail	by	Part II. Other significant conditions cor	ntributing to death but not rest	ulting in the ur	nderlying cause g	iven in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	1.
al Record		Completed							prior to death?	utopsy findings available completion of cause of
Division of Vital	Attending Physiclan: r death. ector: Atter this certifics by the funeral director. I	ition: To Be	25. Was case referred to medical examiner? 1   Yes   2   No	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ther: 4 Nursing		e) ence 6 □Other (Spec ow injury occurred	cify)
Divisi	in Sire	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office	)	28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edicai (		sician: To the best of my kno ner: On the basis of examina and manner stated.						
<b>)</b>	To the within To the comple	M	29b. Signature and title of certifier	AR M	D .	29c. Licer	+740	5 2	9d. Date signed (Monti	h, Day, Year)
ga	7		30. Name and address of person who co	pmpleted cause of death (Item  A D	23a) (Type, I	Print) Eu	Eust	Belti;	nou MC	12/20/
-5	Sta Regist		31. Date filed (Month, Day, Year)  MAY 2. 7	32. Registrar's Signa	ture	best				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** DOLORES MARY /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Facility Name (If not institution, give street and number, Examiner GENESIS HEATH 5. Social Security Number 6. Sav OF SEVERNA PARK SEVERNA PARK AUNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 F Months 331-24-2137 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 ).5,A DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Be Completed by WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DAVID W. PSILAS, 102 MERMAID DR · ANNADOLISMO 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 S Cremation 3 ☐ Removal from State CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of F eral Service Licens 22. Nama and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part I. Enter the disease of complicities is that each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on Cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cerebrovascular accident Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death carificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? funaral director, paga 2 should be datached 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: Tha within 24 hours aftar daath. To the Funeral Director: Aftar this cartificata h 1 Tyes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident fillad in by tha 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) Physician 2804 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Pasadena Koa 0 4304 Nnaemeka Mountain MO 21122 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 7 2004 Registrar

			For State	State of Ma		d / Dep	artment of	Health a		tal Hygie	ene	
			Registrar			Ce	rtificate of	Death			. No 2 () () L	1 1 2 5 5 6
	Physicia	an	1. Decedent's Name (First, Middle, Las Janet S. John							Date of Death Month	Day Year	
	/Medic									lay 26,	2004	7:50 A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, Luther		Death		4c. County of De. Baltimon	
			College Manor  5. Social Security Number 6. Se	7 49	o /le ure	last birthday			4 Hrs lar	Cata of Righ		
	Funeral Director			M 2∑F 7. A9		. Vea	Months Day		Min. (	Date of Birth Month, Day, Y W 14,	ear) 9. 6	rthplace (State or Foreign country)
			Usual Residence of Decedent		6	0		1	INC	)V 14,	1937   VI.	rginia
	yland		10a. State 10b. County		10c. Cit	y, Town or L	ocation					10d. Inside City Limits
	e-fs	cto	Maryland Baltimon	ce e	То	wson						1 ☐ Yes 2 🕅 No
	or 28	by Funeral Director	10e. Street and Number				10f. Zip Code				. Citizen of What (	Country?
	ath w	la La	8033 Strauff Road				21204				SA	
	terma terma	Tue	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origi ban, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - An Black, Wh	
36	s afte	Ϋ́	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 27 1 If Yes, Give Year or Dates:	NO		1 ☐ Yes 2√ N	Specify:			Specify:	White
3	hour turel	edt	15. Decedent's Ed			16a, Dece	edent's Usual Occi	unation		16	b. Kind of Busines	s/industry
Š	in 72 n "ne fedic	plet	(Specify only highest gra	de completed)		(Give	kind of work don DO NDT use retir	e during most ( ed)	of working			w,
212	i with	Completed	Elementary/Secondary (0-12)	College (1-4or 5 5 +	)+)	Teach	ner			E	ducation	
٦	othe othe vent,	Bec	17. Father's Name (First, Middle, Last)					18. Mother	's Name (Fir	st, Middle, Ma	iden Sumame)	
<u>a</u>	should be filed within 72 hours after death with the Maryland not Mently Hygiene. Ind Mentle Hygiene. In marked other than "naturel", or itema 23a or 28e-f show umatic event, it a Medical Examiner must be notified at	To E	Hunter Sutherland	i				Paul	ine De	erthick		
Maryland 21215-0036	~ ~ ~ ~		19a. Informant's Name/Relationship (7				-				ity or Town, State.	Zip Code)
≥,			Lewis M. Johnston	n/Husband	1	_	Strauff			son, MD		
ore	f Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State			osition (Name of matory or other p		Date		c. Location - City o	
Ē	i. Pag tmen tant: tant:		`4 □ Donation 5 □ Other (Specify	()	Me		ematory		5 <b>-</b> 27 <b>-</b> 0		Baltimo	re, MD
Baltimore,	permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr once.		21. Signature of Funeral Service Licen	in		3	2. Name and Add remation	Socie	ty of	MD, In	c.	04.000
	4B= 4 4	9 3		gorchik	I the deat		299 Frede				ore, MD	21228 Approximate
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	one cause on each li	10.	-	itor tria mode or o	ring, saon as o	araiao or ros	phatory arrest	1	Interval Between Onset and Death
	nysician /Medical		disease or condition resulting in death)	a. de	men	tea						years.
	Examiner			Due to (or as	a consec	uence oi):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Lie auto of injury that initiated events	b. Due to (or as	a conseq	uence of):						
	uted	Examiner	Cause (Cleans of Injury) that initiated events	C.								
oʻ	ate be executed ysician and he burial-transit	Ex	resulting in death) Last	Due to (or as	a consec	uence of):		*				
	ate be nysici he bu	Icai		. d								
89	leath certificat attending phy I for use as the	by Physician/Med	IF FEMALE:									1
g B	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	I death 3	Ectopic pregnan	су			23d. Date of d	elivery Day Year
P.O. Box	res that the de signed by the a l be detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of c	194111 51	Other (specify)					
٥.	that the ded by detaction	/ Ph	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	underlying cause o	given in Part I.		23e. Did tobac	co use contribute	to the cause of death?
ds	uires n sign Id be	d b								1 🗀 Yes	2 □ No 3 □ F	Probably 4 🗀 Unknown
Ö	w require been sig should b	lete								24a. Was an	24b. Were a	autopsy findings available
Re	he lav e has	Completed								autopsy performe 1 Yes 2	d2 prior to	completion of cause of
Division of Vital Records,	Attending Physician: The law requires that the death certifica car dath.  octor dath.  octor is the this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	Be C	25. Was case referred to medical					26. Place of		eck only one)	NO ILITE	s 2 No
$\leq$	ysici is cer direc	To B	examiner? 1 Tes 2 V No	Hospital: 1   Inpatie	ent 2	ER/Outpatie	nt 3 DOA	ther		5 🗌 Residend	e 6 Other (Sp	Assisted Living
0	ig Ph ter th neral	L : uc	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry v Year)	28b. Time o		ury at ork?	28d.	Describe how	injury occurred	TIVIE
Ö	andir sath. or: Af	atic	2 Accident investigation	1				Yes 2 N	lo			
Š	lor Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At h c. <i>(Speci</i> i	ome, farm, st	reet, factory, office	9		Location (Stree City or Town, S		Rural Route Number,
	urs al		00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					No. of the second	latara and	d	-/->	
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 V Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best niner: On the basis of and hanner st	examina	ation and/or in	th occurred at the nvestigation, in my	ropinion, death	n occurred at	the time, date	and place, and du	is stated. le to the cause(s)
	o the	Me	29b. Signature and title of certifier		1		29c. Lice	nse number		29d.	Date signed (Mor	
-	- > F 0		I Burnt	Lanen	le	eg li	10 D	2412	-1		May 26,	2004
	1		30. Name and address of person who	completed cause of o	eath (Iter	n 23a) (Type	, Print)					
_	6			NBERG	2/	/WES	T RD	Tou	JSUN	MD	21204	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Sight	ature	all a		,	/		
	Registi	ell.	MAI WILLOW	T grayer John	J	1	The state of the s					

)			For State Registrar	State of Maryland / Department	artment of Health and rtificate of Death		2001	
	Physici /Medi		1. Decedent's Name (First, Middle, La. RRIAN MATTHEU		Timodio of Bodin	2. Date of Death Month MAY	Day Yeer 22,2004	3. Time of Beath 3:30A.
	Examir		4a. Fecility Name (If not institution, giv SULPHUR SPRING RD		4b. City, Town, or Location of Dea		4c. County of Death BALTIMORE	0.0011
	Funeral Director		5. Social Security Number 214-19-1190  Usual Residence of Decedent	Fr. Age (In yrs. last birthday)  Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthp County 1979 MAK	lace (State or Foreign htry)
	e Maryland ta-f show	ctor	10a. State 10b. County  BATIMO	10c. City, Town or Lo	ocation , SYILE		1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If item 27 is marked other then "natural", or items 23a or 28a-1 show or other traumatic event, Ira Madical Examinat by multibul at	Funeral Director	109 GARDEN RIT		10f. Zip Code 21228		g. Citizen of What Coun	
5-0036	or ite		11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (5 ff Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	to Rican, etc.)	14. Race - Americ Black, White,	an Indian, etc.
21215-0	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Menial Hygiene. Important: If Item 27 Is marked other then "natural", any injury or other traumatic event, If a Madical Exp. 2006.	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business/Inc	
	ld be filed v ental Hygie kad othar i ic evant, II	To Be Co	17. Father's Name (First, Middle, Last)	ALSON TT	CTRICIAN  18. Mother's Na  KTECHN.	me (First, Middle, Ma	CONTRAC aiden Surname)	TOR
, Maryland	and 2 shousalth and Market 127 is market traumet		19a. Informant's Name/Relationship (	AS AUNT 714 H	ng Address (Street and Number or R.	ural Route Number, C	City or Town, State, Zip	Code)
Baltimore,	Pages 1 tment of He tant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	BANNEWC	sition (Name of matory or other place)		Oc. Location - City or To	
Bal	permit. Pa Departmen Important: any injury		21. Signature of Fundamental Service Licen		Daugherty Family Funeral by 2601 Mountain Road	<ul> <li>Pasadena, MD</li> </ul>	). 21122	A
	Physician /Medical		shock, or heart failure. List only- Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):		or respiratory arres		Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):				
8760,	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of):				
Box 687	eath certificate attending phys I for use as the	n/Medical	IF FEMALE: 23b. Was decedent pregnant	d			23d. Date of deliver	v
P.O. B	that the death ed by the atte detached for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Ectopic pregnancy   Other (specify)			Day Year
Records,	w requires that been signed t should be det	by	Part II. Other significant conditions of	ontributing to death but not resulting in the ur	nderlying cause given in Part I.	1 ☐ Yes	cco use contribute to the	e cause of death?
Vital Rec	The lay ate has page 2	e Completed	25. Was case referred to medical			24a. Was an autopsy performe	d? prior to com	sy findings available apletion of cause of
f Vii	S S	To B	examiner?	Hospital: 1 Inpatient 2 ER/Outpatien	045-	ome 5 Residence	e 6 X Other (Specify)	SCENE
on of	Jing After fune		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	28c. Injury at Work?	28d. Describe how		. 17.
Division	or Atten	Certification:	Accident investigation    Accident investigation	0,000	7	City or Town, S	et and Number or Rural State) Supplies Spring	Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one)  1 ☐ Certifying Phy 2 ☑ Medical Exam	/sician: To the best of my knowledge, death liner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place restigation, in my opinion, death occurred	, and due to the caus rred at the time, date	e(s) and manner as sta	ted. the cause(s)
	To th Withir To th	Me	29b. Signature and title of certifier	and the	29c. License number		Date signed (Month, D	ay, Year)
	5		30. Name and address of person who	completed cause of death (Item 23a) (Type, I	O.C.M.E.	MAY	22,2004	
			JACK M. 111 31. Date filed (Month, Day, Year)	41 012	11 Penn Street,	Baltimore,	Maryland	21201
	Sta Registr		MAY 2 7 2004	See A Signature	2			

# unpend item#23a,27,28a-f,PER ME,G833,7/8/04eg Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan		artment of He rtificate of D			ene g. No. 2 A A I	10000
	Physic		1. Decedent's Name (First, Mid	Michael T	. Kil	roy			2. Date of Death MAY 24,	2004	3 Time of Docum ()
	/Medi Examir		4a. Facility Name (If not instituti	ion, give street and numb	per)		4b. City, Town, or L	ocation of Death		4c. County of Deat	
			3930 ST JOHNS	<del></del>			ELLICOTT			HOWARD C	
3600	Funeral Director		5. Social Security Number 220 62 2495	6. Sex 7.	. Age (In yrs. I	ast birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6-7-19)	Year) 9. Birtl 52 Ma:	nplace (State or Foreign untry) Ssachusett
/	land ow		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Many a-f sh	tor	MD How	ard	Е	llico	tt City				1 ☐ Yes 2 🛣 No
	or 284	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23a		3930 St. Joh				21042			United St	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Items 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Madical Examiner in ust be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 🛣 Ma  3 □ Widowed 4 □ Divorce	If Yes Give	es? X∑No		Was Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	72 hou		15. Decede	ent's Education lest grade completed)		16a. Deced	lent's Usual Occupation	on	10	Sb. Kind of Business/l	
21	ithin ne.	Completed	Elementary/Secondary (0-12)		or 5+)		kind of work done dur DO NOT use retired)		-	Defense	
	filled v Hygie ther t		17. Father's Name (First, Middle	e, Last)			ontrolle:		(First, Middle, Ma	Intellige	ence
Maryland	id be ental ked o	To Be	Joseph Kilro					Phyllis		alden Sumame)	
ary	shou and M s mar umat	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailin				City or Town, State, Z	îp Code)
	1 and 2 Health a		Judith L. Ki	lroy/Wife				n's Lan	e Ellic	cott City	, MD 2104
Baltimore,			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other	(Specify)	Co.	emetery, cren Lumbi	sition (Name of natory or other place)  a Mem. P	k. 5-28	3-2004	oc. Location - City or 1 Clarksvil	lle, MD
Balt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service	e Licensee MO	1044					Vitzke's Ellicott	Family FH City, MD
	Physician /Medical Examiner	er.	23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. NA  Due to (or	h line.	· INTOX lence of):	er the mode of dying, s	such as cardiac o	r respiratory arres	t.	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>1</b>	as a consequ						ξ
P.O. Box	the death certifiery the attending priched for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 ☐ Fetal It at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	rery Day Year
	uires that signed b Id be deta	by	Part II. Other significent condit	tions contributing to deat	h but not resu	lting in the ur	derlying cause given i	in Part I.		cco use contribute to	the cause of death?
Division of Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certifinin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending.  Zompletely filled in by the funeral director, page 2 should be detached for use a	Completed							24a. Was an autopsy performe 1/2 Yes 2	24b. Were autoprior to condatb? No Yes	opsy findings available of 2 No
V.	sicier certif	o Be	25. Was case referred to medic examiner?	Hospitat:		1010	0.1		(Check only one)		
ion of	nding Phy ith. :: After this e funeral d	n: T	11 Yes 2 No  27. Manner of Death 1 Natural 5 Pend 2 Accident inves	1 □ Inp  28a. Date of I (Month.) tigation  1 □ Inp  1 □ Inp  1 □ Inp  1 □ Inp	njury	R/Outpatient 28b. Time of Injury Unknow	28c. Injury at Work?	2	ne 5 ☐ Residend 18d. Describe how Inknown	e 6 Other (Speci injury occurred	(fy) SCENE
Divis	after des Director	ertificatio	3 ☐ Suicide 6 🛣 Could	mined 289. Place of	Injury - At hor etc. (Specify)	me, farm, stre	et, factory, office	39	8f. Location (Street City or Town 1	et and Number or Rur State) Ins Lane, Ell	al Route Number, icott City, MD
	le Hospita 24 hours le Funere letely filler	edical C	29a. Certifier 1 ☐ Certify  Check onte	ing Physicien: To the be I Examiner: On the basi and manner	s of examinati	rledge, death on and/or inv	occurred at the time, estigation, in my opini	date and place, a	nd due to the caus	se(s) and manner as	stated.
	To # To # Comp	Me	29b. Signature and title of certific	Le MID			29c. License no			Date signed (Month, MAY 25, 20	
Ì	O Bar		3 Name and address of person	n who completed cause of	of death (Item	23а) (Туре, Р	<sup>2</sup> rint) 111 Pe	nn Stree	t, Balti	more, Mary	land 21201
	Sta Registr		31. Date filed (Month, Day, Year MAY 2, 7, 201		istrar's Signati		ports				

with the Maryland r than "natural", or Items 23e or 28e-f show the Modical Exactive roust be notified at filed within 72 hours after Baltimore, Maryland 21215-0036 is marked other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Importent; If Item 27 is marked other
any injury or other traumatic event.

**Physician** 

/Medical

**Examiner** 

10a. State

1748

Director

Md.

**Funeral** 

Director

**Physician** /Medical **Examiner** 

and

The law requires that the death certificate be executed the attending physician as the use Pol detached þ signed pe should page 2 certificate or Attending Physician: director, this filled in by the funeral After 1 hours after death unerel Director: death

Division of Vital Records, P.O. Box 68760,

Hospital within 24 hours a To the Funerel I

2

Examiner Completed by Physician/Medical Be Certification: To Medical

Funerai Be Completed by 3 XWidowed 4 □ Divorced Elementary/Secondary (0-12) 20a. Method of Disposition Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 XNo 9 Unknown 25. Was case referred to medical examiner?

12 yrs. 17. Father's Name (First, Middle, Last) William Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bonnie J. Kirk daughter 1748 Brookview Rd. Dundalk Md. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 26 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore `4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Chnelly Funeral Home Of 7110 Sollers Point Rd. Signature of Edieral Service Licenses art1 Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, now, or heart failure. List only one cause on each line. Due to (or as a consequence of): ATION PNEUMONIA Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ELLING CANCER 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? 2 No

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Cther:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4940 BASTBRAN AVE BATTIMORE

29c. License number

Approximate Interval Between Onset and Deat

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

2 No

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗌 Yes

27. Manner of Death

3 🗌 Suicide

29a. Certifier

4 Homicide

Natural 2 Accident

32. Registrar's Signature

**ORIGINAL** 

V

completely

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev Month Year Physician ANO ERTRUDE 21 10:30 P.M. 2004 May /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner Ellicott City Howard Center Millenium Health & Rehab. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 1 F Months Director 1910 Minnesota 94 April 6, 474-54-1207 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hygiene. Important: If Nem 27 ie marked other than "nature!" ---- any injury or other traumatic averages. 10d. Inside City Limits 10c City Town or Location 10a State 10h County 1 ☐ Yes 2 No Ellicott City Completed by Funeral Director MD Howard 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 21043 U.S.A. 3000 N. Ridge Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Unknown Unknown DeJerold 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Lano - Son 10422 Oueensway Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Resurrection Cemetery 5/27/04 Mendota Heights, MN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Home of Catons-21. Signature of Funeral Service Licenses ville 1630 Edmondson Ave. Catonsville, MD 21228 ue 23a. Pert1. Enter the disease, or camplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) ischemia of Left Les foot /Medical meell Examiner Physician/Medical Examiner Vasarlar Disease or Attending Physician: The law requires that the death certificate be executed use es the burial-trensit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. igned by the attending physicien be detached for use as the buna Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? situs ulcar - secrel has 2 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) 1□ Yes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury et Work? Director: Aftar the in by the funerel 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital Sprillying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of co 0 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Frederick Rd FERNANDE

**DHMH 16 Rev 6/95** 

State Registrar

32. Registrer's Signature

			1 - For State Registrar	State of Maryla				lealth an Death	d Mental F	lygier	21	004	1692
>	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Las NATHANIEL 4a. Facility Name (If not institution, give	MARS	SHAL		y, Town, o	r Location of E	-	22	Day  - 20  Ic. County	Year O L+ of Death	3. Time of Death 5. 20 A M
	Funeral Director	\$100	5. Social Security Number 6. S 249-34-3531  Usual Residence of Decedent		s. last birthday, Yrs.		Days	If Under 24 Hours		Birth Day, Yea O1	26	9. Birthp Coun	lece (State or Foreigr trry) NC
	the Maryland 28s-f show	Director	10a. State 10b. County  MD Anne A  10e. Street and Number		City, Town or L	urni	.e	d the control of the		100 (	Citizen of W		0d. Inside City Limits 1  Yes 2 No
036	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. ad other than "natural", or items 23a or 28a-f show event, If a Medical Examinar most be inclified at	by Funeral	632 Sandy Ridg  11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	e Drive  12. Was Decedent Ever in Armed Forces?  1	U.S. 13.	Was Dec	210		? (Specify Yes or Puerto Rican, etc.)		U_S 14. Race	A - Americk, White,	an Indian,
21215-0036	within 72 ho ene. than "natur to Medical	Completed	15. Decedent's Ec (Specify only highest gra	de completed) College (1-4or 5+)		kind of v DO NOT	vork done use retired	ation during most of d)	working		Kind of Bu		,
73	should be filed vind Mental Hygie marked other t	To Be Co	8th grade  17. Father's Name (First, Middle, Last)  Bubba Chatman	na		Rigg		Lilli	Name (First, Mid	dle, Maide lars	n Sumam hall	9)	hipyard
more,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marks eny injury or other traumatic 2058.		19a. Informant's Name/Relationship (1)  Mary Marshall—W  20a. Method of Disposition  1 ∰Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif)  21. Signature of Funeral Service Licen	Removal from State M	632 Place of Displacements of Comments of	San osition (N majory of cidg al P	ame of other place e ark and Address	Ridge 5/ ss of Facility H Wes	Date 28/04 t	Gle: 20c.	n Bur Location - 0	rnie City or To	Md 2106 wn, State
)  -  -	Physician /Medical Examiner	e.	23a. Part1. Enter the disease, or common shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. UKOSEP  Due to (or as a const	ath. Do not en				ve, Bal		ore l		21215 Approximate Interval Between Onset and Death
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse									
P.O. Box 6	if the death certific by the attending p tached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	⊒Ectopic ⊒ Other (s	pregnancy specify)				23d. Date Mon	of deliver	ry Day Year
ords, P	w requires that been signed b should be det	by	Par II. Other significant conditions of		esulting în the u	inderlying	cause giv	en in Part I.			_		e cause of death?
al Records,	ysician: The law r is certificate has be director, page 2 sh	e Completed	Of Warrant Market and American						pe 1 ☐ Yes	topsy rformed? s 2 🔀 N	pi	rior to com eath?	nsy findings available inpletion of cause of
Vital	Sicia	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2		200	Oth		Death Check on			- 10 - 1	
	Phys or this oral de	. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatie		28c. Injun Worl	4 🗀 1401311	ng Home 5 ☐ Re 28d. Describ				/
	For Attending Fater death. Director: After	Certification:	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		Injury	М	10	<br Yes 2□No	28f. Location		and Numbe		Route Number,
	Hospan 4 hours Funeral ely filled	Medical Cert	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	ysician: To the best of my ki	nowledge, deat	h occurre	d at the timen, in my or	ne, date and p	lace, and due to the	ne cause(	s) and man	ner as sta	ated. the cause(s)
	To the within 2 To the complet	Jed	one)	and manner stated.						,			
			29b. Signature and title of certifier  Groguseu	M.D.			9c. Licenso	1779	31	5	ate signed		
			30. Name and address of person who decorded AMA GEO 31. Date filed (Month, Day, Year)	completed cause of death (Ite  RGESCUL 3  32. Registrar's Sign	ool Sc		HAR	BOR OVER "	HOSPITA STREET, (	L. BALTI	More	H	D 21225
·	Sta Regista		MAY 2 7 2004	Server &	Spa	uls	1						

SARA MENDONS patient lenum As

			Please	Type or Print in Bla					
			For State Registrar	State of Maryland		ent of Health and ate of Death		giene Reg. No. 200	4 15936
	Physici		Decedent's Name (First, Middle, Lass Sara	Ann		Meadows	2. Date of Dea		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give SINAL MUSPITAL	e street and number)		ity, Town, or Location of Dea		4c. County of Dea	
	Funeral Director		Z1Z-44-3/13	ex 7. Age (In yrs. lasi	Yrs. If Un Month	der 1 Year   If Under 24 Hr ns Days Hours Mir		y, Year) C	rthplace (State or Foreign ountry)
	Aaryland show	or	Usual Residence of Decedent  10a. State 10b. County		Town or Location				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Fraust be rotified ≇f	Director	MD NA  10e. Street and Number			Zip Code		10g. Citizen of What C	ountry?
	er death v Items 23g	Funerai	5404 Lewellen 11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was De If Yes, s	21207 cedent of Hispanic Origin? ( pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	U.S.A 14. Race - Am Black, Whi	erican Indian,
5-0036	hours after turel', or Ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes ANO If Yes, Give Year or Dates:		2 No Specify:		Specify:	Black
1215	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or Items 23a or 28a-f show event, I're Medical Exerginst must be notified at	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	work done during most of wo Tuse retired)		16b. Kind of Business	
and 2	d be filed intal Hygi ed other	Be	12th grade  17. Father's Name (First, Middle, Last)	na	OII		me (First, Middle,	State of Maiden Sumame)	Maryland
Maryland	as 1 and 2 should be of Health and Mental is item 27 le marked or other traumatic eve		Lester Wilson 19a. Informant's Name/Relationship (7 Duane Cozart-So			ess (Street and Number or Fi Wellen Driv	lural Route Numbe		Zip Code) 21207
Jore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐	Removal from State	e of Disposition (A	lame of r other place)	Date	20c. Location - City or	Town, State
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.	Ì	21. Signature of Funeral Service Licen	Juli	22. Name	orest Vet. and Address of Facility T F/H West	5/27/04	Owings N	Mills, Md
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused the death. It	4300 Do not enter the m	Wabash Ave ode of dying, such as cardia	Balti c or respiratory arr	more Md est,	21215 Approximate Interval Between
} .	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Severe An		PRAIN INJUR	Y		Onset and Death 48 400-5
E	-341	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequent	nce of):				
Ď,	be executed ician and burial-transit	ШĂ	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	nce of);				
09/89	eath certificate be exe attending physician ar for use as the burial-t	Medicai	IF FEMALE:	d					
	Q 0 Q	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic			23d. Date of del Month	ivery Day Year
cords, P	w requires that the de been signed by the a should be detached t	þ	Pulmonary hyper- Congestive heart	ontributing to death but not resulting	ng in the underlying	g cause given in Part I.		pacco use contribute to	the cause of death?
He	The law ate has b page 2 sl	Completed	Congestive heart ,	failure			24a. Was a autops perform	prior to death?	altopsy findings available completion of cause of
VII	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☑Inpatient 2 ☐ ER/	(Outreties   ST	0#	ath (Check only on		
	ling Phy I. After this funeral d	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		/Outpatient 3 [ [ b. Time of Injury M	28c. Injury at Work?  1 Yes 2 No		once 6 Other (Spec ow injury occurred	pify)
DIVIS	To the Hospital or Attency within 24 hours after death To the Funerel Director: completely filled in by the to	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, facto	ory, office	28f. Location (St. City or Town	reet and Number or Ru ı, State)	ral Route Number,
	To the Hospil within 24 hour To the Funer completely fille	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	vsician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death occurre and/or investigation	d at the time, date and place on, in my opinion, death occu	a, and due to the caurred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of continer		2	9c. License number	25	9d. Date signed (Month	n, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAMAN MALIK JACKSON, MD SINAI MOSPITAL OF BALTIMORE

31. Date filed (Month, Dax Year)

MAY 2 2004

Separation of Sparks

Aparks

RES- PPP

22, 2004

			For State	State of Mary		artment of I		, ,	200	1. 1.500
	Physici	an	1. Decedent's Name (First, Middle, La	st)	Oei	mcate or	Dealli Dealli	2. Date of Dea Month		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, giv	e street and number)	noital	4b City, Town, c	or Location of Deat	MAY	4c. County of Dea	4   13301 M
	Funeral Director		5. Social Security Number 6. S 212-86-3663	VTVM 2□ F	yrs. last birthday)  31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)		rthplace (State or Foreign ountry)  MD
	ryland		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show froust be notified at	Director	MD NA  10e. Street and Number	E	Baltimo	10f. Zip Code		1 1	0g. Citizen of What C	1X Yes 2 □ No
	ath with		6504 Mt Vernon				215		U.S.A	
920	s after , or ite	by Funeral	11. Marital Status  1 X Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l l	Vas Decedent of H f Yes, specify Cub I □ Yes 🌠 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	n 72 hour "naturel edical Ex	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Giva	lent's Usual Occup kind of work done DO NOT use retire	during most of war	king	16b. Kind of Business	
212	filed within 7 Hygiene. othar than "t	Comp	9th grade	College (1-4or 5+)	1	ner			Barber S	hop
land	bed la be	To Be	17. Father's Name (First, Middle, Last, Cofield Manley				18. Mother's Nan	ne (First, Middle, M		
Aary	and and sm	-	19a. Informant's Name/Relationship (	** *		g Address (Street	and Number or Ru	ral Route Number	, City or Town, State,	
	item 27 l		Cofield Manley  20a. Method of Disposition		b. Place of Dispos	sition (Name of	T		more Md	21215 Town, State
Baltimore,	Page: Iment o tent: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	-	morial	Park 5/		Randalls	
Bal	permit, Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licer	5 Kek	22 M 4	Name and Address Acch F/ 300 Wab	ss of Facility H West ash Ave	, Balti	more Md	21215
ł	Pnysician /Medical Examiner		23a. Part . Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	_	travent				norrhay	Approximate Interval Between Onset and Death 7 days
8760,	cartificate be axecuted nding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, it is a label of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
P.O. Box 68	death cartif e attending id for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3 🗌	Ectopic pregnancy Other (specify)	1		23d. Date of del Month	ivery Day Year
	The law requires that the ate has been signed by the page 2 should be detached.	ed by P	Part II. Other significant conditions o	ontributing to death but not	resulting in the un	derlying cause give	en in Part I.		acco use contribute to s 2 □ No 3 □ Pr	37
Division of Vital Records,		Completed						24a. Was an autopsy perform	prior to d	itopsy findings available completion of cause of
f Vit	Physicien: r this certificaral diractor,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatient	3□ DOA Othe		h <i>(Check only one</i> ome 5 ☐ Resider	nce 6 Other (Spec	cify)
sion o	To the Hospitel or Attending Physicien: which 24 hours after deals the full to certific to the Funeral Director: After this certific completely filled in by the funeral director,		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by		28b. Time of Injury	28c. Injun Worl M 1 🗇	/ at	28d. Describe how		any)
Divi	itel or Att irs after d ral Direct led in by		4 Homicide determined	building, etc. (Spe	ecify)			City or Town,		
	To the Hospitel within 24 hours a To the Funeral i completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medicel Exam	ysician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or invi	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th Withir To th comp	Σ	29b. Signature and title of certifier	-+7	+	29c. License			d. Date signed (Month	
	M	-	30. Name and address of person who	completed cause of death (I	tem 23a) (Type P	rint) KL	=>-00		May 20	1 2004
			30. Name and address of person who a  Martin Britos The	Johns Hopkeh	> Hospita	1600 Nor	th wolfe	Street	Baltimore,	Mary land 21287
	Sta Registr	e	31. Date filed (Month, Day, Year) MAY 2 7 2004	32. Registrar's Si	Soo.	Ks				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2.02pm.<sup>M</sup> Edna C. May 2004 MAGNESS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Genesis Eldercare Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 2 □ F MD 11, 1912 92 Director 213-03-8667 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Ellicott City 1 ☐ Yes 2 No Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Items 23a or 3625 Dry Creek Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 □ Yes ZV□ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental Elizabeth Diehlman Willard Cadell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3625 Dry Creek Ct., Ellicott City, MD 21043 Mr. G. Edward Magness (Son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore Natl Cemetery 5/26/04 Baltimore, MD permit. Page Department of Important: If any injury or once. 21. Signature of Funeral Service Licenses <sup>2</sup>HATGHT FÜNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Broncho-pneumonia One week. /Medical Due to (or as a consequence of). Examiner Senile Dementia Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Be Completed by Degenerative Arthritis 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☒ No 24a Was an Osteoporosis. page 2 s 2X No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To 1 ☐ Yes 2 XNo 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 Pending after death.

I Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be within 24 hours after dea To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 13-D 30469. May 24, 2004. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N B Vellanki, MD; 9055 Chevrolet Drive, #100, Ellicott City, MD 21042 32. Registrar's Signatura State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

	1 - For State Registrar	State of Marylan		artment of rtificate o			giene Reg. No. 2	004	16922
ian	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	Day	Үөөг	3. Time of Beath
cal	Edward Milton Mal					May	23	2004	5:40 A M
ner	4a. Fecility Name (If not institution, give	street and number)			, or Location of Dea	th		nty of Death	
	Gilchrist Center 5. Social Security Number 6.S	ex 7. Age (In yrs.	last birthday)	If Under 1 Ye			h	Baltim 9. Birtho	place (State or Foreign
		<b>⊠</b> м 2□F 77	Yrs.	Months Day	rs Hours Min		v. Year)	Coul	MD
To Be Completed by Funeral Director	10a. State 10b. County	10c. City	y, Town or Lo	ocation					10d. Inside City Limits
tor	MD Carroll		W	estmins	ter				1 ☐ Yes 2 X No
Funeral Director	10e. Street and Number			10f. Zip Code	)		10g. Citizen	of What Cou	ntry?
al	47 Bonfire CT			2	1157		1	USA	
nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of If Yes, specify C	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		Race - Ameni Black, White,	
ò	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XSYes 2 □ No If Yes, Give Year or Dates: WWII		1 ☐ Yes 2 🔀 1	lo Specify:		Spe	cify:	White
Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Oce kind of work do: DO NOT use ret	ne during most of wo	orking	16b. Kind o	f Business/In	dustry
dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	III e.	Edi	,		Feder:	a 1 Gov	ernment
ပို	17. Father's Name (First, Middle, Last)			Dul		me (First, Middle,			C I IIII CII C
To B	Milton B. Malan				Alice	Daszkewi	cz		
_	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ing Address (Stre	et and Number or R	lural Route Numbe	r, City or To	wn, State, Zip	Code)
	Marilyn Malan		47 B	onfire (	CT Westm:	inster, M	D 2115	57	
	20a. Method of Disposition  1 X Burial 2 Cremation 3 C		lace of Dispo emetery, cre	osition (Name of matory or other p	niace)	Date	20c. Location	on - City or To	own, State
	'4 □ Donation 5 □ Other (Specify	Lor:	raine	Park Cer	netery05/2	26/2004	Wood?	lawn,	MD
	21. Signature of Funeral Service Licer	see W	\$ 7	2 Name and Ad terling 36 Edmon	Ashton Sondson Ave	chwab Fur Baltin	neral H	Home, MD 212	Inc. 28
er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate.	a. Due to or as a conseq	uence of):		nsition				Approximate Interval Between Onset and Death
dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	⊒Ectopic pregna ⊒ Other (specify)	,			Date of delive	ery Day Year
þ	Part II. Other significant conditions of	ontributing to death but not resi	*	underlying cause	given in Part I.		bacco use c		he cause of death?
Completed		,				24a. Was	sy	prior to co	psy findings available mpletion of cause of
Con			<u>-</u>				med? 2 🔀 No	death?	2 No
Be	25. Was case referred to medical examiner?	Hospital:			Tehne	ath (Check only o	1965		11
on: To	1 ☐ Yes 2 😿 No  27. Manner of Death  1 🛣 Natural 5 ☐ Pending	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. lr	jury at vork?	Home 5 🗀 Resid			W Hospice
Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ome, farm, st		Yes 2 No	28f. Location (S City or Tow		mber or Rura	al Route Number,
edical Ce		ysician: To the best of my kno niner: On the basis of examina and manner stated.							
Me	29h Signature and title of certifier	y Niley.	ans		ense number		29d. Date sig		
		/							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

AP		1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		ne N2 () () ()	16934
Physi		1. Decedent's Name (First, Middle, Las			2. Date of Death Month	Day Year 1, 2004	3. Time of Death 7:36p M
/Med Exam		Ashby May 4a. Facility Name (If not institution, give VA HOSPITAL		4b. City, Town, or Location of Deat BALTIMORE CIT	h	4c. County of Death	
Funera Directo		Social Security Number 6. S	92 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birth Cou 912 Virgi	place (State or Foreign htty) Lnia
aryland show d at	_	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
with the Ma or 28e-f	Directo	MD N/A  10e. Street and Number  3411 Spelman Roa	Balti	.more 10f. Zip Code 21229		Citizen of What Cou	ntry?
Ind 21215-0036  be tiled within 72 hours atter death with the Maryland tall hygiene.  do other then "neturel", or Items 23e or 28e-1 show event, the Medical Execution or the provided at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2X No Specify:		nited Stat  14. Race - Ameri Black, White, Specify: B]	can Indian,
2 2 2	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)  (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)  truction	rking	. Kind of Business/Ir	·
Maryland 212' d 2 should be tiled within th and Menta! Hygiene. ? Is marked other then treumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Ashby May	<del>U</del>		me (First, Middle, Maio	den Sumame)	•
Ma bd 2 st lith ar 27 ts		19a. Informant's Name/Relationship (7)  Ruth Lloyd	Daughter 1044	ng Address (Street and Number or Rockhill Ave. Ba	altimore, N	100000	o Code)
Baltimore, permit. Pages 1 at Department of Hea Importent: If item any injury or othe		20a. Method of Disposition  1	Removal from State    20b. Place of Dispocemetary, crer   New Cathe	osition (Name of matory or other place) dral Cem. 05/2	Date 200 29/04 Bal	Ltimore, M	D.
Balt permit. Depart Import	SIICE	21. Signature of Fineral Service Licen:	1.0	2. Name and Address of FacilityLO1 728 Liberty Road	, Randalls		1133-4784
icate be executed Examine physician and purial-transit sithe burial-transit	ı	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nary Thrombroes	,		Approximate Interval Between Onset and Death
BOX ( ath certil ttending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ery Day Year
cords, P.O. I w requires that the de been signed by the a should be detached t	b		ontributing to death but not resulting in the unknown sclenotic cardu			co use contribute to t	he cause of death?
al Recci: The law ricate has be	Completed				24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
Division of Vital Records, to the Hospitel or Attending Physicien: The law requires the within 24 hours after death.  To the Funerel Director: After this certificate has been signe completely tilled in by the tuneral director, page 2 should be completely tilled in by the tuneral director, page 2 should be completely tilled in by the tuneral director, page 2 should be completely tilled in by the tuneral director, page 2 should be completely tilled in by the tuneral director, page 2 should be completely tilled in by the tuneral director.	Certification: To Be	27. Manner of Death 1 Natural 5 Pending investigation 2 Xaccident 6 Could not be determined	28e. Place of Injury - At home, farm, str	Other: 4 Nursing H  State of S	Cibrar Tour C	njury occurred  e U  and Number or Rura	al Route Number,
Division  To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely tilled in by the			building, etc. (Specify)  which is a specific point of the best of my knowledge, death inner: On the basis of examination and/or in	h occurred at the time, date and place	e, and due to the cause	e(s) and manner as s	tated.
To the P within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner stated.  Linkey NLD  completed cause of death (Item 23a) (Type,	29c. License number	29d.	Date signed (Month,	Day, Year)
7	State	Tasha 2 Gre 31. Date filed (Month, Day, Year)	enhera M.D. 1  32. Registar's Signature	11 Penn Street, E	Baltimore,	Maryland	21201
Regi	strar	MAY 27	ZUU4	Spartes			

1-	For State RegistraMFND TIFM	#5 PER FH G8	Maryland / Dep 31 5/27/04 JHCe				ene g. No. 2001	16935
Physician /Medical	Decedent's Name (First, Midd	e, Last)	erite Nordee			2. Date of Death Month May	Day 2004 Year	3. Time of Death 10:25 a. M
	a. Facility Name (If not institution	n, give street and num Gilchrist Hosp		4b. City, Town, or	Location of Death	timore	4c. County of Dea	ath imore City
Director	Sozial Security Number 38 -4273 213-38-4272	6. Sex 1 □ M 2 F	7. Age (In yrs. last birthday, 62 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) May 30, 1		rthplace (State or Foreign ountry) New York
2 > 10	sual Residence of Decedent Da. State 10b. County  Maryland	Howard	10c. City, Town or L		licott City			10d. Inside City Limits
uth with the Mar 23e or 28e-1 si ust be nutified ral Director	De. Street and Number 2197 Mt. Hebron C	t.		10f. Zip Code	21042	100	g. Citizen of What C U	ountry? .S.A.
5 <u>2</u> <u>3</u>   <u>5</u>	1. Marital Status 1 □ Never Married 2 Mar 3 □ Widowed 4 □ Divorced	ried 1 ☐ Yes If Yes Giv	2 X No	Was Decedent of Hi If Yes, specify Cubar 1 Yes 20 No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours atl Department of Health and Mental Hygiene. mportent: If item 27 is merked other then "naturel", or nny injury or other treumstic event. Ite Midfall Exami Ding.  To Be Completed by F	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1	(Give	edent's Usual Occupa a kind of work done d DO NOT use retired, Hor	during most of work	ing 16	6b. Kind of Business Ow	s/Industry n Home
yland yland build be file Mental Hygher other affic event.	7. Father's Name <i>(First, Middl</i> e, <b>Charles</b>	Last) Thomas McGe	ttigan		18. Mother's Name	e (First, Middle, Ma Ma	aiden Sumame) rie Bower	
and 2 she ashlin and 2 she may 27 is multiple treum	9a. Informant's Name/Relation: Mr. Robert Norde		sband	ing Address <i>(Street a</i> 2197 Mt. Hebr	on Ct. Ellicot	t City, Maryla	ind 21042	
imore Pages 1 Imman of H lury or oth	Da. Method of Disposition  1  Burial 2 Cremation  4  Donation 5  Other (5		DIALE	osition (Name of matory or other place Cremation Sen	) OF	21/2004	Sykesvil	r Town, State le, Maryland
	1. Signature of Funeral Service	ut moos	35	3871 O	uneral Home Id Columbia	Pike Ellicott (	City, MD 2104	
Physician di (Madiga)	29a. Part1. Enter the disease, o shock, or heart failure. Lis mmediate Cause (Final isease or condition esulting in death)	a	aused the death. Do not en ach line.  Or as a consequence of):	ter the mode of dying		or respiratory arres	st,	Approximate Interval Between Onset and Death
7とう  の子   8760, sate be execute only sician and the burial-tran dical Exam	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury autoritiated events estimated events estimated at initiated events.	C	or as a consequence of): or as a consequence of):					
Beath death death defort	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	1☐Live bi	ant at time of death 5[	□Ectopic pregnancy □ Other (specify)	,		23d. Date of de Month	olivery Day Year
	art II. Other significant conditi	ons contributing to de	ath but not resulting in the u	underlying cause give	en in Part I.	23e. Did toba 1 ☐ Yes	_	o the cause of death? robably 4 □Unknown
C 2 2 0 0						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
of Vita Of Vita Physicien This certifi This certifi To Be	<ol> <li>Was case referred to medical examiner?</li> <li>1 ☐ Yes 2 DNo</li> <li>Manner of eath</li> </ol>	Heapital	npatient 2 ER/Outpatient Injury 28b. Time of		ar: 4 🗌 Nursing Ho	n <i>(Check only one)</i> me 5 ☐ Resident 28d. Describe how	ce 6 Uher (Spe	ocity) hospice
Division of Vital Recomplete Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	1 → Natural 5 Pendi	gation (Monti	of Injury - At home, farm, st	Work M 1□Y	res 2□No		et and Number or R	ural Route Number,
Dia Dia Dia Nous after nerel Dir y filled in	9a. Certifier Certifyi	ng Physicien: To the	best of my knowledge, deat	th occurred at the tim	e, date and place,	and due to the cau	se(s) and manner a	s stated.
To the Hosp within 24 hou within 24 hou completely fill Medical	9b. Signature and title of certific	and mann	sis of examination and/or in er stated.	29c. License			e and place, and du	
	O. Name and address of person	who completed cause	e of death (Item 23a) (Type,	Print.	8303	N	14420	2004
State Registrar	7. Date filed (Month, Day, Year MAY 2 7 2	32. Re	es Wy ( agistrar's Signature	060/1	J. Cha	22(0)	15altrum	4 MD 21204

DHMH 17 Rev 1/2001

			1 = For Amend Item 20c, p	State of Ma er FH, GSSI	ryland 57272	Depa			nd Mental		ne 2001	16936
		幣	Registrer  1. Decedent's Name (First, Middle, Last)				imouto of	Dodan	2. Date of		40	3. Time of Death
	*Physicia		Sulaiman	Ab	iodun	ı	Ori	lolowo	Month	-	Day Year	4 1406 PM
	/Medic Examin		4a. Facility Name (If not institution, give str				4b. City, Town,	or Location of			4c. County of Dea	
Was	-Aqiiiii	CI	St. Agnos HEI	4/14h C	ane		Bal	himo	ne			
	Funeral		5. Social Security Number 6. Sex		(In yrs. last	birthday)	If Under 1 Yea Months Days	r If Under 2		Birth Day, Yea	9. Bir	thplace (State or Foreign ountry)
	Director		132-56-5164 XX	M 2□F 5	54	Yrs.	Wioritis Day:	3 Hours	12	14	49 Ni	geria
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation					10d. Inside City Limits
	anyla shov	5										1 Ves 2 □ No
	he M	ecto	MD NA		Balti	Lmore	10f. Zip Code			100 (	Citizen of What C	
	with t	ä	10e. Street and Number					1237		Tog. (	U.S.A.	ountry?
	eath	eral	2362 Hamil Town 11. Marital Status	e 2. Was Decedent I	Ever in U.S.	13 V			in? (Specify Yes o	r No-	14. Race - Am	encan Indian.
10	ter d	Funeral Director	1 Never Married XXMarried	Armed Forces? 1 ☐ Yes 2 1 1					in? (Specify Yes o Puerto Rican, etc	)	Black, Whi	
936	urs al	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 🌠 N	o Specify:			Specify:	Black
Ģ	thin 72 hours after death with the Marylan e. an "natural", or Itams 23s or 28a-f show Medical Examinat must be notified at	Completed by	15. Decedent's Educa (Specify only highest grade	ation	10	6a. Deced	ent's Usual Occi	upation	of working	16b.	Kind of Business	/Industry
75	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5			kind of work don OO NOT use retir					
21	filed withi Hygiene. othar than ant, ILE M	Con		rs+	I	Dept	of P	-				Maryland
pu		Be (	17. Father's Name (First, Middle, Last)						's Name (First, Mi			
<u>ya</u>	Men Men Marke	ဥ	Fasasi Oriolowo						atu Ori			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene, Important: If itam 27 Is marked other than any injury or other traumatic event, ILEN 9009.		19a. Informant's Name/Relationship (Type		1				or Rural Route N			
	1 and Health am 27 thar t		TaJu A. AJ. Boa-	Brother					Balti Date	-	Location - City or	1237
Baltimore,	int of h		1XX urial 2 ☐ Cremation 3 ☐ Rei	moval from State			sition (Name of latory or other pi			Ran	ndallstown	, Md.
莊	it. Pa rtmer rtant njury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signal re of Funeral Service Licensee</li> </ul>		King	-	Norlal Name and Add		5/22/04	- 146	andalls	cowe, Ma
Ba	permi Depa Impo any it		21. Signature of Pulleral Service Licensee	VI		Ma	arch F	/H Wes	t	<b>.</b>		21215
			23a Part Enter the disease or complice	ations that caused	the death. [	On not ente	300 Wal	oasn A	ve, Ba.	rv arrest	ore Ma	21215 Approximate
			23a. Patt1. Enter the disease, or complications, or heartfailure. List only one immediate Cause (Final	cause on each lir				٨.	*	,,,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Acu			anse	1072	retun			
W	Examiner			Due to (or as	a Consequent		(W-	1 = 2 / 50	scular	-las	0 - 0 0	
the		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			C - 10	1 0 000	3 0010	UIJ	601	
_ \	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
S.	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as	a consequen	ce of):						
760	9 y e	cal	d.									
2 89	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	(CCCMA) F.								I	
) X X X	th cer tendii ir use	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	<ul><li>c. If yes, outcome</li><li>1 ☐ Live birth</li></ul>			Ectopic pregnan	ю			23d. Date of de Month	livery Day Year
0.0	e dea he att	slcle	1 □ Yes 2 □ No	4□Pregnant at 9□Unknown	time of death	n 5 🗆	Other (specify)			_	Month	Day real
P.O.	that the de ed by the a detached	Phy	9 ☐ Unknown  Part II, Other significant conditions conti	ributing to dooth b	ut not requitie	a ia tha un	idashina payaa	nuon in Dart I	230	and tobaco	a usa contributa t	o the cause of death?
S. is	w requires that been signed be should be det	by	Part II. Other significant conditions conti	induling to death b	ut not resultin	ig in the un	denying cause g	given in Faiti.		∏ Yes		
A Po	requi	ompleted							_			7
3ec	e law has t	ld m							;	Was an lutopsy performed	prior to death?	utopsy findings available completion of cause of
0 =	ician: The certificate hare	O							1 🗆 Y	9s 2 2N	1 ☐ Ye	
$\mathcal{L}_{\mathcal{C}}$	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	spital:	. 200		C		of Death (Check of		. 50	
200	Phys ral di	L.	1 ☐ Yes 21 No	1   Inpatie	#. I	Outpatient	28c. Ini	4 ∐ Nur	sing Home 5 28d. Desc		6 ∐Other (Spenjury occurred	ecify)
) no	ding Ph h. After th funeral	to	1 Natural 5 Pending	28a. Date of Inju (Month, Da	ý Year)	Injury	28c. Inj W M 1	fork? □Yes 2.□N			,,	
) Sisi	I or Attanding after death. Director: Afte I in by the fune	ertification;	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home	, farm, stre	et, factory, office	е	28f. Locati	on (Street	and Number or A	ural Route Number,
	i i i i i i	erti	4 Homicide	building, et	c. (Specity)				City o	Town, Sta	ate)	
0	pspits hours mara y fille	aC		cian: To the best								
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only one) Medical Examine	er: On the basis of and manner sta		and/or inv	estigation, in my	opinion, death	occurred at the t	me, date a	and place, and du	e to the cause(s)
	To the To the comp	×	29b. Signature and title of pertifier		A :		29c. Lice	nse number	- 2	29d. [	Date signed (Mon	th, Day, Year)
			Att	antho	Phy	sici	an	D185	73		10-1 20	,2004
	2		30. Name and address of person who com	pleted cause of	leath (Item 23	Ba) (Type, I	Print)	13	١.	9.	DO' Cat	on Avenue
_	'		Michael Si	Nerm	$\alpha$	5+ ,	49185	s Hec	Ithcore	ρ.	altho	- Z1229
	Sta		31. Date filed (Month, Day, Year)	- N/	ar's Signature	1	1					
	Regist	iar	MAY 2 7 200	14 /34	nerma	19	Doge	Kal				

			State		artment of Health and			
		_	For State Registrar	Ce	rtificate of Death		1. No. 2004 1693	7
	Physici	an	1. Decedent's Name (First, Middle, Last)  Elizaboth	V. Praetori	1116	2. Date of Death Month May	Day Year 3. Time of Death 26 2004 2:47 E	) <sup>#</sup>
	/Medic Examir		4a. Facility Name (If not institution, give street and no		4b. City, Town, or Location of Dea		4c. County of Death	
	LXaiiii		Gilchrist Hospice		Towson		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2XS F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Birthplace (State or Fore Country) 923 Maryland	iign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Lim	its
	the Mary 28a-f sh	rector	MD Howard  10e. Street and Number	Ellico	ott City  10f. Zip Code	100	1 ☐ Yes 24 ☐ I	No
	h with	ai Di	4729 Parkvale Road		21043		United States	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural; or itams 23a or 28a-f show other traumatic event, the Madical Examinations by Invilled at	by Funeral Director	Armed F	2 <b>X</b> No iive	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:	
21215-0036	'2 hour	ted t	15. Decedent's Education (Specify only highest grade completed	16a Dece	dent's Usual Occupation	orking 16	White Sb. Kind of Business/Industry	
121	vithin 7 ne. han "r	Completed		(1-4or 5+)	kind of work done during most of w	orking	O **	
	filed w Hygie other t		17. Father's Name (First, Middle, Last)	НС	omemaker  18. Mother's Na	ame (First, Middle, Ma	Own Home	
lan'	Aental Aental rked o	To Be	Guy E. Eckenrode		Floren	ce Knobl	ock	
Maryland	12 should be filed within 7 n and Mental Hygiene. 7 is marked other than " raumatic evant, the Meu		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or F		West leader with a second second	
	1 and Health tam 27 other t		Mark Praetorius/Son  20a. Method of Disposition	20b. Place of Dispo	sition (Name of	d Ellico	tt City, MD 2104 c. Location - City or Town, State	3_
<u>o</u>	Pages nent of int: If it iry or o		1 ☐ Burial 2 【XCremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	1 State	matory or other place)  Crematory 5-	27-2004	Catonsville, MD	)
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other tr Q00.09.		21. Signature of Funeral Service Licensee M. Ollins With		2. Name and Address of Facility H	arry H. V	Witzke's Family Ellicott City,	FΗ
	Physician /Medical Examiner		resulting in death i	each line	er the mode of dying, such as cardi		Interval Retween	د
760,	De executed cian and ourial-transit	cai Examiner	Cause (Disease or injury that initiated events c	o (or as a consequence of):  o (or as a consequence of):				
P.O. Box 68	death e atter	by Physician/Medi	23b. Was decedent pregnant 1 Live	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
	w requires that the sbeen signed by the should be detached	ed by Pł	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknow	
I Records,	e taw has b je 2 sl	Completed				24a. Was an autopsy performe		ble of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other	eath (Check only one)		
Division of	ng Phys fter this neral dii	ation: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	Inpatient 2 ER/Outpatier of Injury onth, Day Year)  28b. Time o Injury	IL 3 DOX 4 INdising	Home 5 Residence 28d. Describe how		1 Ce
Divis	tal or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place built	ee of Injury - At home, farm, sti ding, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)	
	To the Hospital or Attandii within 24 hours after death. To tha Funeral Director: A completely filled in by the fu	cai	(Check only 2 Medical Evaminer: On the	hasis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occ	surred at the time date	and place, and due to the cause/s)	
•	with voin	Σ	29b. Signature and title of certifier  Marthony  (C	iley, uns	29c. License number	290 D	NAY26, 2004	
_	1		30. Name and address of person who completed car  31. Date filed (Month, Day, Year)  MAY 2 7 2004	use of peath (Item 23a) (Type,	Print Charles St. B	alto me	1 21205	
	Sta Regist	ite ar	31. Date filed (Month, Day, Yéar) MAY 2 7 2004	Hegistrar's Signature	Spale			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 20, May 10:45 P.™ Mary B. Pokrywka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Village Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year, 6/29/1923 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 25 80 217-16-5250 Yrs. Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortents if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow injury or other treumatic avent, the Medical Example or metal fee invitilised at injury or other treumatic avent, the Medical Example or metal fee invitilised at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD Baltimore Parkville 1 Tyes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8820 Walther Blvd 21234 Apt. 4204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Nowak Carrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benedict A. Pokrywka HUSBAND 8820 Walther Blvd Apt. 4204 Parkville Md 21234 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition St. Stanislaus Cemt. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/24/2004 Department of Importent: If any injury or once. Baltimore Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vach/Rosedale Funeral Home 21. Signature of Fune at Service 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** 2100 Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner the attending physician and hed for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, funeral director, page 2 should be 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1□ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient Certification: To 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 1 within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide Fo the Hospitel 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of leath (Item 234) (Type, Print) 30. Name and address of person 300 31. Date filed (Month, Day, Year) MAY 2 7 2004 32. Registrar's Signar Registrar

unpend item#23a,27,28a-f.PFR MF.(832.6/17/0/eg. Please Type of Print in Black Indelible ink. Ensure All Copies Are Legible. Cory A. Randle State of Maryland / Department of Health and Mental Hygiene 04 - 346616939 1 - For State Registrar AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cory A. Randle May 22,2004 10:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** N/A Bon Secours Hospital Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, JAN 25, 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months **™** M 2□ F 1969 35 Maryland Director 216-06-7008 Usual Residence of Decedent Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 21 No Director Maryland Baltimore Halethorpe the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5896 Selford Road 21227 USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after dealt Department of Health and Mental Hygiene. Important: if itam 27 is marked other then any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: White lf ¥9s, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Allene Ruth Brown Richard Wayne Randle 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5696 Selford Road Richard Wayne Randle/Father Halethorpe, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 5-29-04 Loudon Park Cemetery Baltimore, MD 21. Signature of Fureral Service MacNabo Funeral Home, P.A. 301 Frederick Road Edward A. Catonsville, MD 21228 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part1. Enter the disease, com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic and alcohol intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Be Completed by Physician/Medical Examiner burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Tes 2 \sum No 24a Was an Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 X Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury To Triponth, Day Year) Certification: 28d. Describe how injury occurred found 5 Pending investigation 1 Natural 9:50  $\mathbf{p}^{\mathsf{M}}$ 5/22/04 unknown 2 Accident after death Diractor: 6 XCould not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide street s. monroe st. and wilkens ave., Balt., 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 23, 2004 O.C.M.E. your 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOWER III Penn Street, Baltimore, Maryland 21201 32. Registrar Signatu State Registrar

				State of M	arylan		rtment of F tificate of		Mental Hy	0	100	1001
			1. Decedent's Name (First, Middle, L.	ast)	_				2. Date of D		104	3. Time of Death
-	Physici /Medic		Regina		Re	IdV			Month		Year OOH	1110A1
1	Examin	er	4e Fecility Name (If not institution, gi	ve street end number)		/		4b. City, Town,	or Location of Dea	th 4c. County	of Deeth	
	Funeral		5. Social Security Number 6.	Sex 7. As	ge (In yrs. I	lest birthdey)	If Under 1 Year	Af Under 24 H		irth	9. Birthpla	ce (State or Foreign
	Director		122-10-0//2	1□ M 2□ 8(	)	Yrs.	Months Days	Hours M	Sept		NY NY	ce (State or Foreign y)
	and		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City	, Town or Loc	ation				100	d. Inside City Limits
	Mary	ţo	Md Carroll		Syl	kesvil	le					1 ☐ Yes 2 🔀 No
	or 284	Oirec	10e. Street end Number	JITE			10f. Zip Code			10g. Citizen of \	What Country	1?
	s 23a	Fall	710 Obrecht Road				2178			USA		
020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Haalth and Mantal Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.	by Funeral Director	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Topologogo	12. Wes Decedent Armed Forces? 1 Yes 2 7 If Yes, Give X Year or Dates:		If	/as Decedent of H Yes, specify Cube ☐ Yes 2X No	dispenic Origin? en, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	Blac	ce - Americar ck, White, etc w:white	C.
21215-0020	72 ho	) ted	15. Decedent's E (Specify only highest gr			16a. Decede	ent's Usual Occup	etion during most of w	vorkina	16b. Kind of Bi	usiness/Indu	stry
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g 5	filed v Hygle other t	To Be Completed by	12 17. Father's Neme (First, Middle, Last	1)		1000	JETOHIESE/		ame (First, Middle	, Maiden Suman	10)	
<u>lan</u>	Antal hartal	OB	William J. Reidy					Regina	Beatrice	Cunning	ham	
Maryland	and N is ma		19a. Informant's Name/Relationship					end Number or	Rurel Route Numb	er, City or Town,	State, Zip C	
e)	1 and Haalth Im 27 ther tr		Jane M. Reidy (si	ster-in-la	-	9212 A	ppleford	l Circle	, Owings			
ğ	eges ant of the strict of the		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				ition (Name of etory or other pled			20c. Location -		
Baltimore,	mit. Partme		21. Signature of Funeral Service Lice	**	All	22.	Name and Addre	ss of Facility	5-28-04	Sykesvi	lle, [	<u>1d</u>
ñ	P P F F G	- 1	topiote spire	-Sperber	*	P.	O.Box 19	95 Svkes	ight Fun ville, M	eral Hom d 21784	ie & Cl	iapel
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications thet caused one cause on each li	the death						i In	pproximate iterval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	. End	sta	12	emen	Hia			0	Inset and Death
	-	<b>a</b>	resulting in death)	0	Due to (or	s e consequ	ence of):		- 0 1		7	
	ficata be executed physicien end ss the buriel-transit	edical Examiner	Sequentially list conditions	. Cerel	71 0 8	es a consegu		Accid	ent		d	ays
Ď,	icata be executed physicien end s the buriel-transit	EX	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury			,						,
58760,	cata b physic the b	Gica	that initiated events resulting in death) Last	C	Due to (or	as e consequ	ence of):					
Box				d								
	death certif e attending ed for use e	sicia	Part II. Other significant conditions of	ontributing to death b	ut not resul	lting in the und	derlying cause give	en in Part I.	23b. Did	tobacco use cor	ntribute to th	ne cause of death?
J Ö	v requiras that tha de been signed by the s should be detached	Phy	Hunorlansi	20 00				remin				oly 4 ☐ Unknown
ďŠ,	signed d be d	þ	Hyper Ferrisi	011,00	COF	poros	$n > \alpha$	16/1/10	4		0.4h 14/000	autonou fin dinon
Hecords,	The law requiras that tha ste has been signed by th page 2 should be detache	Completed by Physician/M	osteoarthri	tis, ref	lux	dis	ease	2	24a. Wes	an autopsy ormed?	aveila	autopsy findings able prior to letion of cause ath?
	n: The		25. Wes cese referred to medical			•		00 Di( D	1 🗆		1 □ Y	'es 2□ No
<u> </u>	Physician: The lav this certificete has ral director, page 2	To Be	examiner?	Hospital: 1 ☐ Inpatie	int 2□E	R/Outpetient	3□ DOA Othe	or:	eath <i>(Check only e</i> Home 5 ☐ Resi		er (Specify)	
n 01	ng Ph fter th ineral		27. Menner of Deeth 1 Natural 5 ☐ Pending	28e. Date of Inju (Month, De)	ry y Year)	28b. Time of Injury	28c. Injun Work			how injury occurr		
UIVISION	ttendi death. xor: A / the fi	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e Ope Diseaset lair	Inv - At hos	no farm stro		Yes 2□No	29f Location /	Street and Numbe	or or Pumi D	lauta Alumbar
≥	aftar Direct d in by	Certification:	4 ☐ Homicide determined	building, etc	(Specify)	)	st, ractory, office		City or To	wn, State)	ei oi nuiai n	Sule Mulliber,
		edical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the besis of end menner ste	examinetic	rledge, death on end/or inve	occurred et the timestigation, in my op	ne, date end place pinion, death occ	ee, end due to the curred at the time,	cause(s) and ma date and place, e	nner as state and due to the	id. e cause(s)
_	Vithi To th	Ž.	29b. Signature and title of certifier	1			29c. License	e number		29d. Date signed	(Month, De	/, Year)
	. X		1 - W	1	MC	)	1)00	5813	7	51	240	,4
	10		30. Neme and eddress of person who	completed cause of de	eath (Item:	23e) (Type, P	e St3	307 L	estmine	iter h	10 2	1157
H	Stat	e	31. Dete filed (Month, Day, Year)	32. Registre	er's Signatu	ire for	a Maria					

DHMH 16 Rev 6/95

			For State Registrar	State of M			artment of tificate of				giene g	2004	16941
			1. Decedent's Name (First, Middle, Las	st)					1	2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		Joseph Reneha	in					1		1, 20	004	7:45 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town,	or Location	of Death		4c. Co	unty of Death	
			Frederick Men	orial Ho	ospital		Frede:		0411			ederi	
п	Funeral		5. Social Security Number 6. S 215-34-1572		ge (In yrs. last birti 62	rs.	Months Day		Min.	B. Date of Birt (Month, Day	y, Year)	Coul	
	Director		Usual Residence of Decedent	Λ	02					March	20,194	+2 1	MD
	/land		10a. State 10b. County		10c. City, Town								10d. Inside City Limits
	Many a-f sh	to	MD Howard	l	Syk	esī	ville						1 ☐ Yes 2 ☐XNo
	r 28	irec	10e. Street and Number				10f. Zip Code				10g. Citizer	of What Cou	ntry?
	15 wil	aiD	12680 Old Frederi	.ck Road			21	784			U	SA	
	ams	Funeral Director	11. Marital Status	12. Was Decedent Agped Forces?	Ever in U.S.	13.	Was Decedent of f Yes, specify Cu	Hispanic Ori ban, Mexical	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14.	Race - Americ Black, White,	
36	72 hours after death with the Maryland natural; or items 23a or 28a-1 show iteal Examiner must be notified at	by Fu	1 Never Married 2 Married	1 X Yes 2	<sup>No</sup> 1962−64	Ì	1 ☐ Yes 2 ☑ N					pecify: Whit	
Ö	hour: tural'	d b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ec	l			A dent's Usual Occ					of Business/In	
15	in 72	jet	(Specify only highest gra	de completed)		(Give	kind of work don DO NOT use reti	e during mos	at of working	7	TOD. KING	01 0031110337111	dostry
21215-0036	d within 72 hours after death with the Marylan jiene. Ithan "natural", or itams 23a or 28a-1 show The Madical Examiner must be nutillish at	Completed	Elementary/Secondary (0-12)	College (1-4or		ire	eman				Balt	imore (	County Fire
b	illed I Hygi other	0	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (	First, Middle,	Maiden Su	mame)	
lar	should be ind Mental I marked o	To B	Sydney H. R	lenehan				Ma	ry E1	izabet	h Bar	cus	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Itam 27 Is marked othe other traumatic event,	ľ	19a. Informant's Name/Relationship (	•			ng Address (Stre				-		
Σ.	1 and 2 Health am 27		Mrs. Beverly Rene	han (Spou			01d Fr	ederic					
ore	of Head High High High Head High Head High Head High Head High High High High High High High High		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	y, crer	sition (Name of natory or other p		Da			ion - City or To	
Ë	Pages iment of lant: If it jury or o		`4 Donation 5 Other (Specification)	y)	Cresti		Mem. G	1					.11e, MD
Baltimore,	permit. Pages Department of the Important: If its any injury or of once.		21. Signature of Funeral Service Licer  Bland	Hanka	4	1 22 H	AIGHT F ykesvil	UNERAL 1e, MD	HOME 2178	& CHAP: 4 (410	EL, P. )-795	A (Box -1400	195)
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death. Do n	ot ent	er the mode of d	ying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	. SEPS	is								Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence o	of):							
	Examiner		Sequentially list conditions,		majic		CVA						
	sit s	ine	Sequentially list conditions, if any, leading to immediate the first Underly Cause (Disease or injury		a consequence of		CONT						
_	and and II-tran	Examine	that initiated events resulting in death) Last	C.	a consequence of								
8760,	be executed sician and burial-transit	licai E		`									
687	flicate t physical s the b	edic		_ u.							·		
Вох	eath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	3 F	Terrorio aromas	201			230	I. Date of delive	*
	e death the atte	Physician/Med	in the past 12 months?	4☐Pregnant a			Ectopic pregnar Other (specify)					Month	Day Year
P.0	at the d by the tached	hys	9 Unknown	9Ll Unknown					_				
Vital Records, F	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions of	contributing to death t	out not resulting in	the u	nderlying cause	given in Part I		_	obacco use res 2 1 h		he cause of death? pably 4 Junknown
00	aw requir is been si 2 should	Completed								24a. Was		4b Were auto	psy findings available
Be	o _ o	mo								autop perfor		death?	mpletion of cause of 2□ No
ita	ician: Th certificate ector, pag	a	25. Was case referred to local					26. Ptace	e of Death	Check only o			
	dir d	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpati	ent 2 ER/Out	patier	nt 3□ DOA	Other: 4 🗆 Nu	ursing Hom	e 5 ☐ Resid	dence 6	Other (Specif	ý)
n of	ding Ph h. After th funeral		27. Manne f Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. T ay Yeer) Ir	ime of	28c. In W	jury at fork?	28	3d. Describe h	now injury o	ccurred	
Sio	Attending r death.  ctor: After by the fune	cati	2 Accident investigation					□Yes 2□					
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined	288. Place of in	jury - At home, fai tc. <i>(Specify)</i>	m, str	eet, factory, offic	e	28	31. Location (S City or Tow		lumber or Rura	al Route Number,
	Hospital 24 hours a Funeral D		20a Cartifica 1 Prartituing Ph	nysician: To the best	of my knowledge	doat	h conversed at the	timo data ar	ad place, as	od dua to tha	221100(0) 22	d mannar as s	tatad
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai		niner: On the basis of and manner s	of examination and								
	To the within 2 To the complet	M	29b. Signature and title of certifier		1 _			nse number				igned (Month,	
	/\		Juecell C	Deecelk	5DU		05-	-010	753	_	MA	120	zovy
	4		30. Name and address of person who										
	· ·		Francisco Daniel		7th St.	, F	rederic	k, MD	21701				
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 7 2004	Server 32. Regist	rar's Signature	po	rks						

			1 = For Stata Registrar		of Maryland		artment of rtificate o			Re	g. No.	004	16942
	Physici		Decedent's Name (First, Middle,     WILLIE	•	RATLIFF				2	t. Date of Death Month	Day	Year /	3. Time of Death 2055 P M
	/Medic Examir		4a. Facility Name (If not institution,				4b. City, Town	n, or Location of	of Death	May	4c. County	of Death	1
		.>-	Saint Agnes		hearl		Bal	timor	re			N	A
	Funeral Director		5. Social Security Number 242-24-4582	3. Sex 1 🖾 M 2 🗆 F	7. Age (In yrs. last	t birthday) Yrs.	Months Day	ar If Under ys Hours	Min. 8	. Date of Birth (Month, Day, 1-28-	Year)	9. Birthp Cour	place (State or Foreign ntry)
			Usual Residence of Decedent							1 20	1723		
	Manyla f shov	or	10a. State 10b. County		10c. City, T							1	0d. Inside City Limits 1 X Yes 2 □ No
	r 28e-	Director	MD N/A	1		BALTI	MORE 10f. Zip Code	9	-	10	g. Citizen of	What Cour	
	th with	ai D	4544 MOUNTVIEW	ROAD			2	1229			U	SA	
	er dea	Funeral	11. Marital Status	12. Was Dec Armed F	edent Ever in U.S. prces?	13.	Was Decedent of f Yes, specify Co	of Hispanic Ori uban, Mexican	gin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		ce - Americ	
Š	urs after	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 X Yes If Yes, Gi Year or D	ve salat		1□Yes 2ሺN	No Specify:			Specif	y: BLA	VCK
č	72 hou	eted	15. Decedent's (Specify only highest	Education	1	6a. Deced	dent's Usual Occ	cupation	t of working	11	6b. Kind of B		
Š	within ne.	Completed	Elementary/Secondary (0-12)	College (			kind of work dor DO NOT use reti	ired)	t of working		DOOMIN	rc /par	RBERING
Ċ	filed v Hygie Sthert		17. Father's Name (First, Middle, Li	ast)		BA	RBER	18. Mothe	er's Name (F	First, Middle, Ma			KDEKING
1	Jan Jid be Jental Irked o	To Be	PRENTICE RATLIFI	3						RIVERS			
	DESILIMOTE, INIGITYIBING Z.I.Z.I.3-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "naturel", or Items 23e or 28e-1 show appringny or other treumetic event, In. Mudical Exam and control of an appress.	ľ	19a. Informant's Name/Relationshi				ng Address (Stre					. ,	*
	C, R 1 and Health em 27 ther t		JOAN E. RATLIFF,	WIFE	20b. Place		MOUNTV sition (Name of	TEW KD	• DAI	LTIMORE	c. Location		21229
	Dallimore, Sernit. Pages 1 ar Department of Hea mportent: if item; any injury or other		1 ☑ Burial 2 ☐ Cremation 3		State ceme	etery, cren	natory or other p	. !					
=	mit. F partm. porter y injur		21. Signature of Funeral Service Li		KING		ORIAL PA		5-28-2 <sup>y</sup> JAME		RTON 8	SONS	MARYLAND S F.H., INC.
	Dermi Departiment		James	a. The	rton	1	701–31 I	LAURENS	ST.	BALTIM	ORE, M		AND 21217
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that only one cause on o	caused the death. [	Do not ent	er the mode of d	tying, such as	cardiac or re	espiratory arres	t,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Myscard	• •	infasc	hon					in known
20.00	Examiner				(or as a consequen	ce of):							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events	b Due to	(or as a consequen	ce of):							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Duo to	(or as a consequen-	an af):							
9	cate be executed physician and sthe burial-transit			Due to	(or as a consequent	Ce oi).							
9	certificate ding physise as the	edic		0.									
0	J C 2 3	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy pirth 2 Petal de		Ectopic pregnar	ncv				te of delive	,
711	es that the death igned by the atter be detached for the	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of death		Other (specify)				Mo	onth	Day Year
015	that the ed by detac		Part II. Other significant condition	s contributing to d	eath but not resultin	ig in the ur	nderlying cause (	given in Part I.		23e. Did toba	cco use cont	ribute to th	e cause of death?
116	requires requires been sign should be	ed by								1 ☐ Yes	2 🗆 No	3 🗌 Prob	ably 4 Donknown
_	2 a a c	Completed								24a. Was an autopsy	24b. 1	Were autor	psy findings available inpletion of cause of
	VICAL DESIGNATION SICION: The lav certificate has rector, page 2	Com								performe	g (	death?	2 No
-	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Nu		Check only one)			
0.7	Phys or this oral dii	. To	1 ☐ Yes 2 ☑ No 27. Man r of Death	28a. Date	of Injury 28	Outpation  b. Time of	t 3□ DOA 28c. Ini			5 Residend			"
F	Attending F r death. sctor; After	atlor	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investiga		th, Day Year)	Injury		lork? □Yes 2□N	No				
-	l or Attendate death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place	of Injury - At home ing, etc. (Specify)	, farm, stre	eet, factory, offic	e	28f	Location (Stre City or Town,		er or Rurai	l Route Number,
100	ospitel or hours afte unerel Dir ly filled in		COn Contilion 15 Continue	Physician, Takh	heat of my broude				<u> </u>				
X	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier 1 ✓ Certifying (Check only one)	<b>caminer:</b> On the b	e best of my knowled asis of examination ner stated.	and/or inv	estigation, in my	time, date and y opinion, deat	a place, and th occurred	at the time, date	se(s) and ma e and place,	inner as sta and due to	ated. the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier.	c Mi)				nse number	<del></del>		. Date signed		
	200		m					17353		M	ay 2	4, 2	.004
	18/1/2		30. Name a d address of p son w		se of death (Item 23 ば 光がらた。そん	a) (Type, I	Print) D Caton	Avenus	84	lhuste	Mari	land	21229
	Sta	te	Jon Falck MD  31. Date filed (Month, Day, Year)	32. F	Registrar's Signature	1 40	0	711-4100			7		1
	Registr	25	MAY 2 7 2004	Seney	pe po	M	outs!						

			1 - For State RegistrarAMFND ITFM #23e  1. Decedent's Name (First, Middle, Last	State of Ma	ryland / Dep 3831 5/27 <b>/04</b>	artment of H	lealth and	Mental Hyg	giene leg. No. 20 (	1694
П	Physici		EORGE	ROMLEY				2. Date of Dea Month	Day Yea	
	/Medi Examir		4a. Facility Name (If not institution, give Good SAMARITAN	HOSPITA		BALTI	r Location of Deat	MD		N/A
	Funeral Director		5. Social Security Number 6. Set 1568-72-9706 Usual Residence of Decedent	x 7. Age	(In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1950 Ca	Birthplace (State or Foreign Country) Ilifornia
	ie Maryland Ba-f show utilied at	Director	Md. 10b. County	4	10c. City, Town or Le					10d. Inside City Limits 1 X Yes 2 □ No
	with the	Dire	10e. Street and Number 1635 Winford Ro	1		10f. Zip Code 212	39	1	log. Citizen of What I	Country?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Mental Hygiene titem 27 is marked other than "natural, or Items 23a or 28a-f show other traumatic event, If a Marical Example at must be notified at	by Funeral		12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 🛛 No	lispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)		nerican Indian, nite, etc. White
1215-0	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5-	(Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of wo d)	rking	16b. Kind of Busines	
nd 2	ould be filed w Mental Hygie larkad othar t letic evant, L	To Be Co	17. Father's Name (First, Middle, Last) Fred George Ro	<u>5+</u> omley	Clei	^gy		me (First, Middle, I Susanne	Religio Maiden Sumame) Nicola	ous
	1 and 2 should I Health and Meni am 27 is marka		19a. Informant's Name/Relationship (Ty Mr. Fred Romley/			ng Address <i>(Street</i> agamore R			; City or Town, State 1. 10708	, Zip Code)
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Disponsion Commetery, creating Greek Or	matory or other plac			20c. Location - City o	
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Furneral Service Liters	hgan		Name and Addre Ruck Tows LO50 York	on Funer	al Home,	Inc. 21204	
	Physician // Medical // Examiner // Stansif // Ltansif	Ical Examiner	23a. Part 1. Enter the disease, or compile shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	LEVRE C		F THE LIVER		Approximate Interval Between Onset and Death
P.O. BOX 08	Phyaician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at t	P Fetal death 3□	Ectopic pregnancy	,		23d. Date of d Month	elivery Day Year
ras, r	quires that n signed b uid be deta	Ď	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 2 Unknown
al Kecords,	: The law requ cate has been , page 2 shoul	Completed						24a. Was an autops perform	y prior to ned? death?	autopsy findings available completion of cause of s 2 No
Vital	alcian: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?	lospital:	A 0 5 5 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	t 30 DOA Oth	or	th (Check only on		
on or	nding Physith. th.: After this funeral di	atlon; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	t 2 ER/Outpatier  28b. Time o Injury	28c. Injun	y at		once 6 □Other (Sp ow injury occurred	ecify)
DIVISION	Hospital or Attending 44 hours after death. Funaral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
	To the Hospital of within 24 hours aff To the Funaral Discompletely filled in	Medical (	29a. Certifier (Check only one) (Check only one) (Check only one)	sician: To the best of ner: On the basis of and manner stat	my knowledge, deatlexamination and/or in ed.	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	tuse(s) and manner a ate and place, and du	as stated. se to the cause(s)
	Tot Tot comp	Σ	29b. Signature and title of certifier	Calconer	-, MD	29c. Licenso	e number		9d. Date signed (Mor	nth, Day, Year)
6	+1		30. Name and address of person who co	NNEN 56	OI LOCH R	AVEN BL	VD. BAL	TIMORE,	MD 212	39
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 7 2004	32 Registra	's Signature App	uld				

			For State Registrar	Please	Type or Pri State of M		nd / Depa	artmei	nt of H	ensure A dealth and National N	•	ygien	_		16944
	Physici /Medic		1. Decedent's Name Henry Jo	o (First, Middle, La ohn Roem							2. Date of D May 23	,200	ay Y∈ 4	ar	3. Time of Death 7:48 a. M
	Examin				ve street and number, Hospital	)			seda	r Location of Death 1e			e. County of D Baltim		
-	Funeral Director		5. Social Security N 212 42	6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6	Sex XXX M 2□F	ge (In yrs 59	. last birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of B Month, 1 11/16/	1944 1944	9.	Birthpi Coun Mar	ece (State or Foreign try) yland
	Maryland -f show	tor	Usuel Residence of 10a. State MD	Decedent  10b. County  Baltime	ore		osedale							10	0d. Inside City Limits 1 ☐ Yes 277No
	h with the	Funeral Director	10e. Street and Nur 1106 Ch	esaco Av	enue			10f. Z	p Code	237		_	itizen of Wha	Coun	try?
24	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic svent, if a Medical Examinations to be notified at once.	by	11. Marital Status  1 Never Marri 3 Widowed	ed <del>X</del> Married 4 □ Divorced	12. Was Decedent Armed Forces 1  Yes 2  If Yes, Give Year or Dates:	?		Was Dece If Yes, spo 1  Yes		dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	10-	14. Race - A Black, V Specify: W	Vhite,	etc.
ter R	in 72 ho n naturi	Completed		15. Decedent's E	ducation rade completed) College (1-4or	E.)	16a. Dece (Give life.	dent's Usi kind of w DO NOT	ual Occup ork done	pation during most of world)	king	16b. I	Kind of Busin	ess/Inc	lustry
7, H	d be filed with ntal Hygiene ed other the sevent, tre	Be	Elementary/Seco 12 17. Father's Name Henry J		0	3+)	Trucki	ing		18. Mother's Nam	ne (First, Middle 1de Lehi	le, Maide	f empl	oye	d
Roemer, Baltimore, Maryland	nd 2 should alth and Me 27 is mark	To	19a. Informant's Na	ame/Relationship		FE		-		and Number or Ru Avenue Ro	ral Route Num	ber, City			
Roeme, Mary	Pages 1 a nent of Hea int: If item iry or othe				Removal from State	20b. Pa	Place of Dispo cemetery, cree rkwood	osition (Na matory or Ceme	ame of other place tery	5/27/	Date 2004		ocation - City kville		wn, State
Balti	permit. Departn Imports any inju		21. Signature of Fu	neral Service Lice	ensee		12	2. Name a 211 C	nd Addre	ss of Facility Cva co Avenue	ch/Rose Rosed	edale ale l	e Fune Maryla	ral nd	Home 21237
•	Physician /Medical Examiner	liner	23a. Part1. Enter to shock, or hea Immediate Cause of isease or condition resulting in death)  Sequentially list out any, leading to impause. Enter Under Cause (Disease or that initiated events)	rt failure. List only (Final n	a. Due to (or a	ONA s a conse	quence of):	Λ i	de of dyin	*		arrest,			Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	that initiated events resulting in death) I	ast	Due to (or as	s a conse	quence of):								
P.O. Box	To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physiclan/Medical	IF FEMALE: 23b. Was deceden in the past 12 1  Yes 2 ( 9  Unknown	months? ∃No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fet	tal death 3	⊒Ectopic   ⊒ Other (s		/			23d. Date of Month		ry Day Year
d. G	signed b	by	Part II. Other signif	icant conditions	contributing to death	but not re	sulting in the u	inderlying	cause giv	ren in Part I.					e cause of death?
A Division of Vital Records,	sicien: The law requir certificate has been si irector, page 2 should	Completed	Ch	Ronic	anen	nia	**************************************		-		24a. Wa aut per 1 □ Yes	opsy formed?,	prior	to con	osy findings available apletion of cause of
Vita	sicien: certific rector,	Be	25. Was case refer examiner?	/	Hospital:		<b>I</b> ER/Outpatier		OA Oth	26. Place of Dea			- CO		
o	g Phys er this eral di	n: To	1 ☐ Yes 2 ☐	h	28a. Date of Inj (Month, D		28b. Time o		28c. Injur Wor	4 🗀 Mulaing D	28d. Describe			pecity	)
× ivision	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending investigate 6 Could not determined	be 380 Blace of Ir	njury - At I	home, farm, sti	М	1 🗆	Yes 2 □No		(Street a		r Rural	Roufe Number,
` 0	Hospital c 24 hours af Funeral D stely filled in	Medical Cer	29a. Certifier (Check only one)	1 Certifying P	thysician: To the bes	of examin	nowledge, deat nation and/or in	h occurre	at the tir	me, date and place	and due to the	e cause(s	and manne d place, and	r as sta	ated. the cause(s)
	To the within. To the comple	Mec	29b. Signature and	title of pertifier	Phiphs			25	c. Licens	se number		29d. Da	ate signed (N	onth, L	Day, Year)
	13		30. Name and addr	ess of person who	completed cause of	death (Ite	em 23a) (Type,	Print)	ee .	RD. To	BAIto,	M	217	13	7.
	Sta Regist		31. Date filed (Mon	2 7 2004	32. Regis	trar's Sign	nature	Spa	KN						

		•	for State Registrar		State of	Maryla	nd / Depa	artmen rtificate			and M	•		004	16945
	Physici /Medic	al	1. Decedent's Name (First, M. Lanier Ratc	liff	e		-	4. 63.	Fa	Landin		2. Date of De Month		Year 2004	3. Time of Death 4:45 A
	Examin	er	4a. Facility Name (If not institute Summerford  5. Social Security Number		e Ass	isted	Livin	g Co	luml	Location of Oia		8. Date of Birt	How	ard	place (State or Foreign
	Funeral Director		235-66-9824 Usual Residence of Decedent	1	м ЖДГ	90	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year) 9,1913	Cour	ntry)
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36	s 1 and 2 should be filed within 72 hours atter death with the Maryland of Health and Mental Hygtene. item 27 is marked other than "neturel; or Items 23a or 28e-f ehow other treumetic event. The Madical Examinational be inclifted at	by Funerai	9534 Caboos  11. Marital Status  1 Never Married 2 N  3 Widowed 4 Divor	larried	12. Was Dece Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 <b>X</b> No e		2104 Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	Blac	ce - Americ ck, White,	etc.
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Baltimore,	permit. Pag Department Importent: any injury once.		21. Signature of Funeral Serv		20		>	2. Name an	d Addres	s of Facilit	y Wit	zke Fu	neral	Home	es,Inc.
	Pnysician /Medical Examiner	iner	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	or compli	a <b>A</b> Due to (	aused the dea ach line.  DVANCO or as a conse	ath. Do not en	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	:OLUMD1 rest,	.a,	proximate proximate proximate proximate nonset and Death
Box 68760,	death certificate be executed e attending physician and id for use as the burial-transit	Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 grooths?	2	d. 3c. If yes, out	come of pregi	nancy tal death 3[	Ectopic pri						te of delive	ory Day Year
P.O.	that the de led by the a detached i		1 ☐ Yes 2 No 9 ☐ Unknown  Part II. Other significant con	litions cor	9□ Unkno	)W/I		Other (sp		n in Part I.	,	23e. Did to	obacco use cont	nibute to th	ne cause of death?
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Il Record	The lay ate has page 2	Completed							· · · · · ·		<del></del>	24a. Was autop perfo 1 Yes	rmed?	Were auto prior to con death? 1 \( \sum \text{Yes}	psy findings available inpletion of cause of
Division of Vital	Attending Phyeicien death. ictor: After this certiti y the funeral director	ertification; To Be	3 ☐ Suicide 6 ☐ Co	F	28a. Date of (Mont)	of Injury h, Day Year)	28b. Time o Injury	M 2	8c. Injury Work	or: 4□ Nu	rsing Hon 2 No	28d. Describe h	dence 6 Goth	er (Specif) red	
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	1		30. Name and address of per		mpleted caus	e of death (Ite	em 23a) (Type, CHAN1		NIVE	#	200	COLUM	SIA AD	2/01	<i>f</i> 4
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MAY 26, 2004 2:20 a.m.

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	Physici /Medic		1. Decedent's Name (First, Mode, Last)	SON	2. Date of Death Month Da	ay Yeer 3. Time of Death 7004 845A M
	Examin Funeral		4a. Facility Name (If not institution, give street and number)  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)  216-14-3509  14 M 2 F  80 Yrs.	4b. City, Town, or Location of Death    W   S   M L	8. Date of Birth (Month, Day, Year AUG. 16, 19	g. Gounty of Déath  R. F. T. M. O. R. F.  9. Birthplace (Stete or Foreign Country)
, -	Director		216-14-3509	Location	AUG.16,19	23 MD
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5-0036	hin 72 hours atter death with the Maryland B. Madical Examiner mutt be notified at Madical Examiner mutt be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Divorces?  1 Divorced  1 Wes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Pican, etc.)	Black, White, etc.  Specify: WHITE
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yland	should be file nd Mental Hy marked oth matic event	To Be (	17. Father's Name (First, Middle, Last)  ROBERT  ROBINS	ON TENA	e (First, Middle, Maider	ADLER
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altimore,	Pages 1 and ment of Healt ant: If item 2 ury or other		1 La Buriai 2 Cremation 3 Permoval from State 1	ematory or other place) 5/1//	U4	Location - City or Town, State WINGS MILLS, MD
Balt	permit. Pag Department Important: I any injury o			22. Name and Address of Facility $S0$ 8900 REISTERSTOWN		
<b>)</b>	Physician /Medical Examiner	SY.	Dua to (or as a consequence or).	nter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
8/60,	certificate be executed triing physician and ise as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
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al Kecord	The lay ate has page 2	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
ion of Vital	Attending Physician: Th r death. actor: Atter this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiper?  1	ent 3 DOA Other: 4 Nursing Ho	th (Check only one) ( ome - The sidence 28d. Describe how inju	
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	wii To CO		29b. Sighar Gand title of certifier ,			AY, 2 2004
			30. Name and address of ge on p of cause of eath (Item a) (Type 31. Date filed (Month, Day, Year)  32. Registrar's Signature	33 SK Johns,	LANE E	14,2 2004 Liker 0,54 md
	Sta Registr		oz. riegistra s signature	books!		

Mark Schultheis Maryland Baltimore. Box 68760. P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2110 PM Mark Douglas Schultheis 19 2004 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death **Examiner** City Baltimore Sinai of Baltimore Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 17€ M 2 F 213-64-2846 Yrs. 50 Director MD June Usual Residence of Decedent 10c. City, Town or Location 10a State 10b Count 10d. Inside City Limits or 28e-f ehow traumatic event, the Medical Examinar must be notified at MD Director Carrol1 1 Yes 2 No Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a 3416 Millie Way 21102 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hyglene, other than " iled within Elementary/Secondary (0-12) College (1-4or 5+) Counterman Auto Parts 12 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental John Howard Schultheis Evelvn Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Suzanne Schultheis (Wife) 3416 Millie Way Manchester, MD 21102 Health item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 5/24/2004 Important: I any Injury o Sykesville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>2</sup>HATGHT<sup>A</sup>FUNERAL HOME & CHAPEL, PA (Box 195) 2. ALL Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Henniation and Midline Shift with **Physician** troke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Diabetes 3 Probably 4 Unknown 1 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 Y 1 Dipatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 19, 2004 RES-000 and address of person who completed cause of deal lite 23a) (Type, Print) Sinai HOSP 31. Date filed (Month, Day, 32. Registrar's Signatur Registrar MAY 2 7 2004

			1 - For State Registrar	State of Mary		artment of I		d Mental H	ygiene Reg. Nq2	104	16949
	Physici /Medi		Decedent's Name (First, Middle, La Florence	M. Shotts				2. Date of Month	Death Day	Year CY	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Sacred Hea	rt Hospit			erland	Death	4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 214-03-9952  Usual Residence of Decedent		n yrs. last birthday) 8 Yrs.	If Under 1 Year Months Days		Min. 8. Date of I (Month, Feb. )	Birth Day, Year) 10 1916	9. Birthp Cour Pe	olace (State or Foreign htry) ennsylvania
036	72 hours after death with the Maryland natural', or items 23a or 28a-f show after Examination publical	by Funeral Director	10a. State Md.  Allega  10e. Street and Number  100 Village P  11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	ny		10f. Zip Code 2153	Hispanic Origin pan, Mexican, F	.? (Specify Yes or uerto Rican, etc.)	10g. Citizen o	of What Cour US, ace - Americ lack, White,	A can Indian,
Maryland 21215-0036	be filed within tal Hygiene. Id othar then avant, the Mer	Be Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) UNKNOWN  17. Father's Name (First, Middle, Last Charles Shaw	College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	Name (First, Midd		troni	
	ges 1 and 2 should be f t of Health and Mental I If Itam 27 is marked of or other traumetic ava	To	19a. Informant's Name/Relationship ( Mr. Victor Decatu  20a. Method of Disposition	r/ Grandson		Box 1170	and Number o	nr Rural Route Nun nnon, WV	nber, City or Town		
Baltimore,	permit. Pages 'Department of H Important: If Ita any injury or ot once.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Special 21. Signature of Funer Legislation Licerates)	Removal from State (y)	cemetery, creatory, creators oreland	matory or other pla Mem. Parl	k	28-04 uneral Ho Towson,		ille,	
8760,	Physician /Medical Examiner and the buriat-transit	dical Examiner	23a. Part1. Enter the disease, or common shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	pilications that caused the one cause on each line.  a. SEPS I'S  Due to (or as a co	o death. Do not entirely on sequence of):	ter the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Onset and Death G days
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Division of Vital Records,	Physician: The law re this certificate has be ral director, page 2 sho	Be Completed	25. Was case referred to medical examiner?	Hospital:		O#		per 1 ☐ Yes Death Check on	opsy formed? 2 No	prior to cor death? 1 Yes	osy findings available inpletion of cause of 2 No
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•	To the P within 24 To the F complete	Medi	29b. Signature and title of certifier  Wowschaft	M O	•	29c. Licens	se number		29d. Date sign	ed (Month, I	Day, Year)
	Sta	te_	30. Name and address of person who WDNSCCK SMIN 31. Date filed (Month, Day, Year)		Terrare Signature	Print) Fiest	-bury	HD 21	532		
	Registr		MAY 2 7 200	4 Brue	Dr. Ages	AS !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** EBORAH 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** AAN DALISTOWN HOSPITAL NORTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreig Country) **Funeral** Days Hours 1 ☐ M 2 🗷 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28e-f ehow treumatic event. The Medical Examiner must be notified a 1 Yes 2 No Be Completed by Funeral Director BALTIMORE MARYLAND 10e. Street and Number 10g. Citizen of What Country? or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 215 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 □ Divorced "naturei", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BANK ADMINISTRATOR 11 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked o ELLIOTT 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tre once. KANDALLSTOWN ESTHER MONTGOME 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State RBUTUS CEMETERY 05-26-04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of scility BROWN 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CUTE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Dio Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 200NO Hospital: Other: npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tyes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation after death. 1 🗌 Yes 2 🗌 No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Se Bagistran's Signature

AUI

Y-2004

To the

29c. License number

7333

M021133

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:15 PM Anthony Thomas 05 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Center Examiner Bultmore Baltimere City Univesity MD- SLOCK Treme If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 17,1990 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours 1√M 2□F 161-72-9458 14 Pennsylvania Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Iteme 23a or 28a-1 ehov any injury or other traumatic event. If a Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Manchester Carroll Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21102 USA 3260 Main Street by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Student 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gary Alan Thomas Connie Sue Meadows 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Connie Sue Massicot, mother 3159 High Street, Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 05/27/2004 Hanover, PA \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fy eral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician fre brain /Medical Due to (or as a consequence of): **Examiner** vehile Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included as one of the cause of the Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has contistons 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XYes 2 No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after decret Attended Motor vehicle -19-04 1 ☐ Yes 2 No ~ 11 00 PM 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide R4.27 Ing: towarde within 24 hours a To the Funerel E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435-1505 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Widow Shak ort 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State	of Maryla		artmer			and M	lental Hy	giene Reg. No	200	14	16952
			Decedent's Name (First, N	liddle, La	ıst)							2. Date of De	ath		7 7	3. Time of Death
	Physici /Medi		Phillip	Ear1	L Tha	alheime	r					Month May 2	Da 4 2	у Үе 004	er	7:25 P M
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			19 Marley Ne						n Bur		24 1150			Anne A		
	Funeral Director		5. Social Security Number 217-38-5851		Sex 1₽M 2□F	7. Age (In yr	s. last birthday	Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da Dec 20	th $y$ , $Year$ ), $194$	9. M	Birthpla Counti D	ace (State or Foreign ry)
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	r 28a-	Director	10e. Street and Number	S AL	under		Tasaue		p Code				10g. Cit	izen of Wha	t Count	ry?
	h with	I D	8283 Patapsco	Roa	ad				21122	2				U.S.	Α.	
	deat deat	Funeral	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13	Was Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - A Bleck, V		
30	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or Items 23e or 28e-f show event, tre Medical Eventral roual for rotified at	by Fu	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo		1  Yes If Yes, G Year or [	2∭XNo ive				Specify:	, , , ,	Thousa, oto.,		Specify:		
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<u>.</u>	s 1 and 2 should f Health and Mer Item 27 le merke other traumatic		20a. Method of Disposition			20b	. Place of Disc	osition (Na	me of	-		Len Bur		cation - City		
9	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☑ Cremat 1 ☐ Donation 5 ☐ Other			State Ch	cemetery, cr nesapea				lay 2	27,2004	Ste	vensv	ille	, MD
Baltimore,	permit. Pages 1 Department of H Important: if Itea eny injury or oth		21. Signature of Emeral Ser			•		2. Name a	nd Addres	s of Facility	Si	ngleton	Fun	eral H	Iome	РА
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S	s after	Certification:	4  Homicide de		build	ing, etc. (Spec	cify)					City or Tou	m, State	)		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a. Certifier Cert (Check only one)	itying Plical Exe	hysicien: To the miner: On the b and man	e best of my ki	nowledge, dea nation and/or i	th occurred evestigation	at the tim i, in my op	e, date and pinion, deat	f place, a	and due to the ed at the time,	cause(s) date and	and manner place, and o	as stat	ed. he cause(s)
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	10		30. Name and address of per	son-who	completed cau	se or death (Ite	em 23a) (Type	Print)		3.11	Ties	10 6	+ 1	B	×.	1 7 W.
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			Registrer  1. Decedent's Name (First, Middle, Last)	ennicate of Death	2. Date of Death	j. No 0 0 %	3. Time of Death
Е	Physici		Paul Joseph Thomas		Month May 23	Day Year	0145 a <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	0270
			Shock Trauma  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Baltimore  # Under 1 Year   If Under 24 Hrs.	9 Date of Birth	n/a	ace (State or Foreign
Н	Funeral Director		215 28 0579 XXM 2 F 73 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) 09/21/19	gear) Country Mary	ry)
	Pu *		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town o	Location			d. Inside City Limits
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	or 28a	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Countr	ry?
	ath wit	ralD	2407 Greenheart Lane	21040		USA	
980	72 hours after death with the Maryland natural', or tems 23s or 28s-f show deat Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Notion of the state of t	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecity Yes or No- Rican, etc.)	14. Race - America Black, White, e	
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ylaı	should be and Mental marked o	<b>To </b>	Joseph Thomas		Zellinger		
Maryland	8 8		1.11	ailing Address (Street and Number or Run 5 Grace Manor Drive			
re,	- T = =	3	20a. Method of Disposition 20b. Place of Di cemetery,	sposition (Name of crematory or other place)	Date 20	c. Location - City or Tow	
Baltimore,	nit. Pages partment of h ortant: If its injury or of		4 Bonation o Bother (openity)	Cemetery 05/27	7/04 Ea	astwood MD	21224
Ball	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licensee	1211 Chesaco Avenue	Rosedale	ale Funeral	Home 21237
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
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Vital		a	25. Was case referred to medical	26. Place of Deal	th (Check only one)	No 10 Yes 2	2 No
of V	S .E	To B	examiner? 1 ★ Yes 2 No Hospital: 1 ★ Inpatient 2 □ EP/Outpa			ce 6 Other (Specify)	
o uc	fing After fune	tion:	27. Manner of Death  1 Natural 5 Pending Sakural investigation investigation	e of 28c. Injury at Work?  Work?  1 ☐ Yes 2 12 No	28d Describe how	injury occurred	be in hist
Division	tan leat tor: the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28 Place of Injury - At home, farm	/	28f. Location (Stree City or Town,	et and Number or Rural	oute Number,
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	Hospi 24 hou Funar tely fill	Medicai	29a. Certifier    Certifying Physician: To the best of my knowledge, do the control of the cont				ted. the cause(s)
<b>•</b>	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	Mec	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, D May 24, 200	
	10/		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) 111 Penn Stree	t, Baltim	ore, Maryla	nd 21201
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 7 2004 32. Registrar's Signature	Sparker			
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		-	Registrar  1. Decedent's Name (First, Mich.)	idle last)				Ce	rtiiicat	e or i	Death	12	. Date of Dea	ag. No.	UU4	16951
1	Physici /Medi		Stanley Hac	k Ve					, <del></del>			М	ay 25	<sup>Day</sup> 200		1940 м
	Examir	ner	4a. Facility Name (If not institut Gilchrist H			umber)					r Location of D imore	eath		4c. Cou	nty of Death a	
Wa.	Funeral Director		5. Social Security Number 242-52-5356	6. Sex	M 2□ F		(In yrs	last birthday) Yrs.	If Under Months	r 1 Year Days	If Under 24 Hours N	Ain.	Date of Birth (Month, Day)		9. Birth Cou	olace (State or Foreign ntry) Carolina
5	land ow		Usual Residence of Decedent 10a. State 10b. Cour					y, Town or Lo	cation	1			2-10-			10d. Inside City Limits
6-	72 hours after death with the Maryland 72 hours after death with the Maryland Insturel; or Items 23e or 28e-f show diget Exactline must be profiled at	ector	MD	n/a			Ва	ltimo								1€Yes 2□No
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\( \sigma_{\frac{1}{2}} \)	= p = 2 t		19a. Informant's Name/Relation Antoinette M			pou	se				and Number of Avenu					
55			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		emoval from	State	l _	lace of Dispo emetery, crer		me of other place	e) 5 /	Date / 27 /	2004	20c. Locatio	-	
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	/Medical Examiner		resulting in death)		Due to	(or as a	consequ	lence of): 🜙								
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9	BOX 001	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23	3c. If yes, ou 1⊟Live 4⊟Preg	birth 2	2 ☐ Fetal	death 3	Ectopic pr						ate of delive	ery Day Year
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	Physician: Physician: or this certific aral director,	To B	examiner? 1 Yes 2 No 27. Manner of Death	Ho	28a. Date	of Injury		ER/Outpatien			er: 4 🗆 Nursin	g Home	5 Reside	nce 6	ther (Specif	Hospite
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certify (Check only 2 Medical	ring Physi al Examin	ar: On the t	e best of pasis of e	examınat	wledge, death io <i>n</i> and/or inv	occurred estigation,	at the tim , in my op	e, date and pla pinion, death o	ace, and ccurred a	due to the ca	use(s) and rate and place	nanner as si o, and due to	ated. the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certif	ier M	1	-1				. License				d. Date sign		
	6		30. Name and address of perse	n who con	npleted cau	se of de	th (Item	23a) (Type,	Print)	1))	5005		C: 1	AAYS	26,0	2004
	Sta	to	31. Date filed (Month, Day, Yea	ey y	32. F	Registrar	U C	6 7	011	Y-C	hard	2-	V. K	alt	- md	2120/2
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 1- State Registramento TIEM #17 PER FH C831 5/27/04 JICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2000 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death INIVERSITE ISSIM BALTIMORE pecintul If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month. Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 228-14-399 1 □ M 2 F Director Feb Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 27 is marked other then "neturel", or items 23a or 28a-f show traumetic event, the Medical Exemprer must be notified at 10d. Inside City Limits WIA Director 1 es 2 No WD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should ba filed within 72 hours aftar death with nent of Health and Mental Hygiene. ranklin 2430 1223 Funeral d Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ressev 17 Father's Name (First, Middle, Last) ERNEST Maryland BROWN 18. Mother's Name (First, Middle, Maiden Sumame) ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Health other husbad Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City permit. Pages Department of i Important: If it eny injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Torrest 21. Signature Fune | Service Licensee 22. Name and Address of Facility ences fier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrova /Medical Examiner bele うの Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) use as the burial-transit or Attending Physicien: The law raquires that the death certificate be axecuted mass resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy Year 4☐Pregnant at time of death 5 Other (specify) Day 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes 2 Z No 1-1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation within 24 hours after daath.

To the Funerel Director: All completely filled in by the fu daath. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (frettan) May 24th 2004 34974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) MAY 2 7 2004

CHARU MEHTA, MD

32. Registrar's Signature

601 South

Sparks

charles street, Baltimore, MD 21230

VILLAMS

		For Amend Item #18, per Registrar  1. Decedent's Name (First, Middle, Last)		CET	tificate of	Death	Reg	2004 g. No.	1 6 9 5
Physicia /Medic	an al	Edith V. Weaver		1			Month May 2	2 y 2004 Year	10:10 PM
uneral irector		Homewood Nursin  S. Social Security Number  214–14–6335  Usual Residence of Decedent  10a. State  MD  Homewood Nursin 6. Sex 1 N 10b. County Washingto	ng Home 7. Age (In yrs. 94	Yrs. y, Town or Lo	Willi If Under 1 Year Months Days	amsport If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Feb 28,	1910 Mary	lace (State or Foreig
or 28a-f	Directo	10e. Street and Number		WIII	10f. Zip Code		10	g. Citizen of What Cour	
item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event. I'm Medical Examiner must be notified at	by Funeral Director	16505 Virginia Aven  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	ue B314  . Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates:			795 Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	USA  14. Race - Americ Black, White,  Specify: Whi	etc.
than "natura Le Medical E	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion	(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of word) -	king	6b. Kind of Business/Ind	
arked other than	To Be Co	17. Father's Name (First, Middle, Last) Frank Edgar Carba	ugh			18. Mother's Nam	ne (First Middle Mi ra Viola Be iola Beek	aiden Sumame)	
Is mar raumati		19a. Informant's Name/Relationship (Туре Robert Weaver/spouse				and Number or Ru	ral Route Number,	City or Town, State, Zip	
Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Ren  1 ☑ Donation 5 □ Other (Specify)	20b. P	lace of Dispo	sition (Name of natory or other place			liamsport, Oc. Location - City or To	
Importar any inju	Ì	21. Signatur 1 Funeral Sovice Licensee Ronal S (18	Je, jrector	8t	Name and Addre ate Anat ltimore,	omy Board		Baltimore S	treet
sician edical aminer	Examiner	23a. Part1. Enter the disease or complications, or heart failure. List only one Immediate Cause (Final disease or con.) on resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mittated events c.	cause on each line	uence of):	1	.4	correspiratory arres	,	Approximate Interval Between Onset and Death
g physicia as the but	Physician/Medical Exa	resulting in death) Last	Due to (or as a consequence of pregnation of decisions o	incy	Ectopic pregnancy	у		23d. Date of delive Month	ny Day Year
been signed by should be deta	þ	Part II. Other significant conditions contributed and Care of	ibuting to death but not res				23e. Did toba	acco use contribute to th	ie cause of death? ably 4 ∏Unknowr
2 S	Completed	,					24a. Was an autopsy perform	prior to co	psy findings available inpletion of cause of 2 No
r this certin	tion: To Be	25. Was case referred to medical examiner?  1  Yes	spital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	ner: 4 Nursing H	ith (Check only one) Iome 5 Residen 28d. Describe how	ice 6 Other (Specif	()
r: Afte	CCI		One Disease flaires. At he		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number.
If Director: Afterd in by the func	Sertifica	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specif	,,					
he Funeral Director: Afte	edical Certification:	4 Homicide determined  29a. Certifier 1 Certifying Physic		wiedge, death					ated.
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certifica	4 Homicide determined  29a. Certifier (Check only 2 Madical Examine	building, etc. (Specifican: To the best of my known: On the basis of examina	wiedge, death		opinion, death occu	irred at the time, dat		ated. the cause(s)

**ORIGINAL** 

		1 - State Registrar  1. Decedent's Name (First, Middle, Last		d / Department of H Certificate of	Death	Reg. N		69
ysicia Medica	an al -	ESTHER H. BO	OTTOMLEY	O'T Town		MAY 21	2004	3. Time of Death 8:04a
amine	er	4a. Facility Name (If not institution, give 402 Lime Land:			r Location of Death		County of Death	
eral		5. Social Security Number 6. Se	ex 7. Age (In yrs. las	st birthday) If Under 1 Year	ington If Under 24 Hrs. 8.	Date of Birth	Queen Ar	nne's lace (State or Fore try)
ector			□M 2XIF 93	Yrs. Months Days	Hours Min.	(Month. Dav. Yea	1911 Pen	nsylvan
벽		10a. State 10b. County	10c. City,	Town or Location			10	0d. Inside City Lim
Delli	ctor		Anne's Mil	lington				1 ☐ Yes 2 🙀
imatic event, the Madical Examinar must be notified at		10e. Street and Number		10f. Zip Code		10g. C	Citizen of What Coun	itry?
nust	eral	402 Lime Landi	ing Rd.  12. Was Decedent Ever in U.S.	21651	<del></del>		S.A.	te diam
Iner	Fur	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No		lispanic Origin? (Specify an, Mexican, Puerto Ric	y Yes or No- an, etc.)	Black, White, e	etc.
Evam	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 25€ No	Specify:		Specify: Wh	ite
dical	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of working	16b.	Kind of Business/Ind	dustry
8 Mes	mp	Elementary/Secondary (0-12)	College (1-4or 5+)				Colo	-
nt.		12 17. Father's Name (First, Middle, Last)		Owner-Oper	18. Mother's Name (F		air Salo:	n
C eve	To Be	Benjamin Hendr			CAtherin		snown	
other treumatic	F	19a. Informant's Name/Relationship (T)		19b. Mailing Address (Street				Code)
i i		Karen Price	(niece)	P.O. Box 1	3 Galena	a, MD. 2		******
		20a. Method of Disposition	20b. Plac	ice of Disposition (Name of metery, crematory or other place			Location - City or Tox	wn, State
July or		1 ☐ Burial 2X Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Memoval Irom State	t Cremation	5/22/		nyrna, Di	
any injury or once.		21. Signalure of Fundral Service Literas	0//	22. Name and Address Galena F	uneral Ho	me of S	Stanhan '	r Scha
ē Ö		(1)		TO TTO MEST	CIUSS SU	· Garei	la, MD.	21035
7		23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	dications that caused the death, one cause on each line.			espiratory arrest,		Approximate Interval Between Onset and Death
cian		Immediate Cysse (Final disease or condition resulting is death)	101	1 1				Ollogi and Domin
	d Disease	resulting is death)	u	mers demen	tia			4 MYS
lical iner		resulting is death)	Due to (or as a consequent	mers denen	tia			4 yrs
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#### Please Type or Print in Black Indelible Ink Ensure

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			1 _ State		artment of Health and M			10000
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Death	Reg	g. No. 2004	16959
	Physici	ian				2. Date of Death Month May 19,		3. Time of Death
>	/Medi		HELEN THERESA BUT  4a. Facility Name (If not institution, give street in the content of the cont		4b. City, Town, or Location of Death	May 19,		2258 P M
	Examir	ner	Malcolm Grow Medica			D	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Andrews Air Force   If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince Geo	
	Director		577-38-8618 1 1 M 2		Months Days Hours Min.	8. Date of Birth (Month, Day, )		ace (State or Foreign ry) D.C.
	P .		Usual Residence of Decedent			4/2//5	Wasii	• D • C •
	arylar	<u></u>	10a. State 10b. County	10c. City, Town or Lo			10	d. Inside City Limits
	88-1	octo	MD P.G.	Temple				1 XYes 2 No
	with the	급	10e. Street and Number		10f. Zip Code		g. Citizen of What Count	ry?
	d within 72 hours after death with the Maryland Jione. r than "natural", or Itema 23a or 28a-f show Tra Medical Exercites rounts be notified at	Funeral Director	3126 Brinkley Rd.	#201 as Decedent Ever in U.S. 13.	20748		U.S.A.	
10	ter dea	Fun	An	ned Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - America Black, White, e	
036	urs al	by	3 Widowed 4 Divorced Ye	Yes 2 No 'es, Give ar or Dates:	1 ☐ Yes 2√2 No Specify:		SpecifyBlac]	ζ.
Ö	2 ho	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation	. 16	6b. Kind of Business/Ind	ustry
21	c * @	ple	(Specify only highest grade comp Elementary/Secondary (0-12) Co	llege (1-4or 5+)	kind of work done during most of work DO NOT use retired)	ing		
2		Con	12	Sup	ervisor	Po	ostal Serv	vice
pu		Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	iden Surname)	
78	should be nd Mental marked o	2	James A. Thomas	- Transma	Iola S			
Maryland 21215-0036	12 har		19a. Informant's Name/Relationship (Type, Pri		ng Address (Street and Number or Rura			Code)
	1 an Heal am 2		Gary Butler/son  20a. Method of Disposition	20b. Place of Dispo	Mace Dr. Ft. Wa		. 20744 lc. Location - City or Tow	en State
о́	ges # tot		1 ☐ Burial 2 Cremation 3 ☐ Remove		natory or other place)			
Baltimore,	+ E E =	l Y	* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Riverda	le Crematory 5/	26/04 F	Riverdale	Md.
Ba	permi Depar Impo any ir		Anien) Edu	ruda 2	Name and Address of Facility HOI	DGES ANI	EDWARDS	
	, <u>.</u>		23a. Part1. Enter the disease, or complications (shock, or heart failure. List only one caus	that caused the death. Do not ent	910 Silver Hill er the mode of dying, such as cardiac of	r respiratory arrest	tland, MD2	20746 Approximate
	Pnysician :		Immediate Cause (Final	se on each line.	หน้าสามาจาร์ พ			nterval Between Onset and Death
-	/Medical		disease or condition resulting in death)	Due to (or as a con equence of):	Junes			
	Examiner		Sequentially list conditions b					
	P ==	iner	if any, leading to immediate cause. Enter Underlying	ue to (or as a consequence of):	`.			
2	be executed ician and burial-transit	Examiner	Cause (Disease of Injury that initiated events c. resulting in death) Last	ue to (or as a consequence of):				
60	ate be executed nysician and he burial-transit	calE		oc to (or as a consequence or).				
687	ficate phys s the		d.					
Вох	eath certificat attending phy I for use as thi	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If y	es, outcome of pregnancy			23d. Date of delivery	,
ă	death certifica e attending ph d for use as th	Physician/Med	in the past 12 months?	Pregnant at time of death 5	Ectopic pregnancy Other (specify)			ay Year
0	at the de by the a tached	hys	9 Unknown 9L	Unknown				
S,	requires that the een signed by thi	by P	Part II. Other significant conditions contributing	g to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
ord	w require been signature					1 ☐ Yes	2 No 3 Probab	oly 4 Unknown
Records,	aw Is b	ple				24a. Was an autopsy	24b. Were autops	y findings available of
E.		Completed				performed	d?   death?	□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)		
of	S S	2	1 X Yes 2 No Hospital	1 Inpatient 2 AER/Outpatien			e 6 Other (Specify)	
n		Certification;	1 □Natural 5 □ Pending	Date of Injury 28b. Time of Injury Injury	Work?	28d. Describe how i		e-attended
Division	teal deal tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury At home, farm, stre			t and Number or Ryral F	
<u>&gt;</u>	in Direct	ertif	4 Homicide determined	building, etc. (Specify)	the made	City or Town, S	tate) Interscent c	N St. Banusia
_	Hospital or 24 hours affe Funeral Dir tely filled in		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the caus	Airs Rol T. H.	ad
		edical	(Check only 2X) Medical Examiner: Of	the basis of examination and/or inv manner stated.	estigation, in my opinion, death occurre	d at the time, date	and place, and due to th	ne cause(s)
	To the within To the comple	M	29b. Signature and title of certifier	21 1	29c. License number	29d.	Date signed (Month, Da	y, Year)
			MAN	W	O.C.M.E.	Ма	y 20, 2004	
	5	1	30. Name and address of person who complete					
	~		S. R. HOGAN		Penn Street, Bali	imore, M	aryland 212	01
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 7 2004	32. Registar's Signature	Sugar to at "			
DHI	MH 17 Rev 1/20	왕, 글		professor so	62 St.			

			1 - For State of Maryla		artment of Healt rtificate of Dea			ene . No. 200	<u> </u>
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Frances Virginia Boswell				2. Date of Death Month 1ay 15, 2	Day Year 2004	3. Time of Death 11:15 A M
2	Examir	er	4a. Facility Name (If not institution, give street and number)	L N C	4b. City, Town, or Locati	tion of Death		4c. County of Dea	
	Funeval		Hermitage of St. John's Cree 5. Social Security Number 6. Sex 7. Age (In y	yrs. last birthday)	Solomons If Under 1 Year   If Uni	nder 24 Hrs.	8. Date of Birth	Calvert	
	Funeral Director		214-68-9415 1☐ M 21 F 83 Usual Residence of Decedent	Yrs.	Months Days Hou	urs Min.	(Month, Day, Y Sept. 12	, 1920 Ma	thplace (State or Foreign buntry) aryland
	Marylan a-f show	tor	10a. State 10b. County 10c.  Maryland Calvert	. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 🛣 ☐ No
	or 284	Jirec	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	ountry?
	s 23e	rail	13325 Dowell Road		20684-15			USA	
386	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic avant, illu Mached Examinate results to multified at ODGe.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2X No Spec		cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	72 hor	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	most of workin	16	b. Kind of Business	Industry
2	/ithin ne.	mpie	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during n DO NOT use retired)	most of working	9	•	
22	illed w Hyglei thar ti nt, th	Ö	fo 17. Father's Name (First, Middle, Last)	Н Н	omemaker 18 M	Inther's Name	(First, Middle, Ma		Home
ä	d be f	To Be	unavailable				ia Cecel		
3	should be and Mental marked o	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Nur				Zip Code)
ž	and 2 alth a 127 ls er trei		Frances Broussard - Daughter		Box 431, Vi				
Baltimore,	Pages 1 lent of He nt: If itan ry or oth		1 N Burial 2 Cremation 3 Removal from State		sition (Name of natory or other place) ion Cemetery			inton, MD	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee M01246		Name and Address of Fa Huntt Funera P. O. Box 156	acility Home	22/11/12/20		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a constitution and constitution)	monic	er the mode of dying, such				Approximate Interval Between Onset and Death
3/60,	ate be executed hysiclan and he burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underrying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consideration of the co						
P.O. BOX 6	or Attanding Physician: The law requires that the death certificate be executed lifter death.  Itter death.  After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregular in the past 12 menths? 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
ds, г	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not to Chasmic Alnah fauth		nderlying cause given in Pa	art I.	23e. Did tobac	_	the cause of death?
ဂ် လ	s beer s shou	olete	Azrlythmia				24a. Was an	24b. Were au	topsy findings available
al He	ysician: The lav is certificate has director, page 2 a	Completed	Dementia				autopsy performed 1 ☐ Yes 2 ☑	death?	completion of cause of 2□ No
5	yslcia is certi directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	2 ☐ ER/Outpatien	Other	/	Check only one)	e 6 □Other (Spec	
Division of Vital Records,	nding Phy th. r: After thi e funeral c		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			28	3d. Describe how i		ary)
DIVIS	Hospital or Attank 4 hours after death Funeral Diractor: tely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe	t home, farm, streetify)	eet, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medicai C	29a. Certifier (Check only one)  12 Certifying Physicien: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	knowledge, death lination and/or inv	occurred at the time, date restigation, in my opinion, c	e and place, and death occurred	d due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier		29c. License numbe		29d.	Date signed (Month	n, Day, Year)
			) safrey	AN	D0594	109	0	5.17.04	
^	٥.		30. Name and address person in completed cause of death (II				MD		
(1)	P 22		Dr. Issa Yusuf, 110 Hospital  31. Date filed (Month, Pay, Year)  32. Registar's Sig		rrince Frede	erick,	שועו		
	Sta Registr	ાલ ar	31. Date filed (Month, Day Year) 32. Registar's Sig	e the	Costs				

			1 - For State Registrar	State of Ma	ryland / Dep		Health and	Mental Hyg	iene og. No 2004	10001
			Hegistrar  1. Decedent's Name (First, Middle, Last	)	06	runcate of	Dealii	2. Date of Deat		3. Time of Death
	Physici		Ruth		+ 1			Month	Day Year	14
	/Medic Examir		4a. Facility Name (If not institution, give		tingham	4b City Town	, or Location of Dea	April	30, 200 4c. County of Dea	4 11 PM
	Examil	iei	Salisbury Nursing		Center	or oxy, rown	Salisbu		Wicomico	
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Yea	r If Under 24 Hrs	8. Date of Birth		thplace (State or Foreign ountry)
	Director		215-20-0726	JM 2 <b>X</b> (F 8	4 Yrs.	Months Day	s Hours Min	. (Month, Oey, 10/30/19		yland
	P ,		Usual Residence of Decedent					10/30/13	720 Mar	yrand
	arylar show	<u>_</u>	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	8a-f	scto	MD Somerset		Pocomoke					1 □ Yes 2/X No
	with th	ă	10e. Street and Number			10f. Zip Code	•	10	g. Citizen of What Co	ountry?
	s 23	graf	7357 Dividing Cr			218			USA	
	Item Item	ņ	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ex Armed Forces?		was Decedent of If Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puer	to Rican, etc.)	14. Race - Ame Black, Whit	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ont, I're Medical Ezaru act must be politied at	by Funeral Director	3 Widowed 4 □ Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		1□Yes 2N	o Specify:		Specify:	
Š	2 hou	Ped	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occ	upation		6b. Kind of Business	White
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+	life.	kind of work don DO NOT use retii	e during most of wo	orking		,
7	d with	Completed	9	none		Homemake	r		Own Home	
덛	al Hy I oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M		
<u>a</u>	Ments Ments arked	10	James Walter Rey	nolds			Mattie	Mutersba	ugh	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if them 27 Is marked other than "natural; or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at Once.		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailii	ng Address (Stree			City or Town, State,	Zip Code)
2	and and n 27 n 27 ner tr		David Brittingham	n/Son	1520	Inglesi	de Ave.,	Perryvill	e, MD 2190	)3
ore	of Ho fiter		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pi			0c. Location - City or	
<u>Ē</u>	Pag ment ant: I ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	temoval isom State	Salisbury	Cremat	ory   05/	03/2004 s	alisbury,	MD
Baltimore,	permit. Departimport any inj		21. Signature of Funeral Service Licens	ee	H	Name and Add	ress of Facility neral Hom	e		
ш_	20 E 29.		AMESOT NIKA		00295 11	673 Som	erset Ave	Prince	ss Anne, N	D_21853
			3a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the caused the	he death. Do not ent	er the mode of dy	ring, such as cardia	c or respiratory arre	st,	Approximate Interval Between
, 1	Physician		Immediate Cause (Final disease or condition	Cereti	al X	ten a	as how			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	73-4-	J			miner
	CXammer	_	Sequentially list conditions,	Hyper	den,	m				9 Ron-
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Doe to (or as a	consequence of):					
	and and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a	consequence of):	<del>.</del>				
760,	cate be executed physician and the burial-transit		4	Due to (or as a	consequence or):					
87	physics the l	dical		d						
9 xo	leath certific attending p	Physician/Med	IF FEMALE:	3c. If yes, outcome of	Dreanancy					
ရှိ	atten for u	lan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of del	ivery Day Year
o.	the d	yslo	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	ine or death 5 E	Other (specify)				,
مز	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/ Ph	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	uires sign Id be	d by						1 🗆 Yes	2 ₽No 3 ₽Pr	obably 4 Unknown
Ö	w require been sign	Completed						24- 146	0.45 114	
Ř	he lav s has ge 2	ш			<u>.                                    </u>			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
g	sician: The certificate hi	e Co	25. Was case referred to medical					1 Yes 2	⊒No 1 ☐ Yes	2 No
⋚	Physician: r this certifice ral director, p	<u>m</u>	examiner?	lospital:	2 ER/Outpatien	0000	h /	ath (Check only one		
ō	Phys or this oral di	1: To	27. Manner of Death	28a. Date of Injury (Month, Day)		28c. Inju		28d. Describe hov	ce 6 Other (Spec	erfy)
0	nding F tth. :: After e funer.	tloi	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )	rear) Injury		ork? ]Yes 2∐No			
Division of Vital	il or Attending after death. Director: After I in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	/ - At home, farm, stre (Specify)	et, factory, office	)	28f. Location (Stre	et and Number or Ru	ral Route Number,
á	P T I	Certification:	4 _ nomicide	building, etc.	(Ѕреспу)			City or Town,	State)	
	ospit hour unere ly fille		29a. Certifier 1 Certifying Physical Exami	sician: To the best of	my knowledge, death	occurred at the t	time, date and place	, and due to the cau	ise(s) and manner as	stated.
	To the Hospital within 24 hours a To the Funeral ( completely filled	Medical	one)	ner: On the basis of eand manner state	d.			irred at the time, dat	e and place, and due	to the cause(s)
	o time o	2	29b. Signature and title of certifier			29c. Licen	ise number	290	d. Date signed (Month	, Day, Year)
			MANI	4-7		190	1181	2	15/04	
	:		30. Name and address of person who co	mpleted cause of dea			Division	C+ C	n-1:-1	W1 03004
			31. Date filed (Month, Day, Year)	32. Regis ar's	1-11	1340 5.	DIVISION	sc.suite,	Salisbury	Md.21804
	Sta Registr	-		2004 Dec		har. V.				

DHMH 17 Rev 1/2001

RUTH BRITTINGHAM

State of Maryland / Department of Health and Mental Hygiene 2 () () State Registrar AMEND ITEM #24a PER VERB FC831 5/27 Contribute of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May Month Day 2004 Year **Physician** Donald Lee Baker, Jr. 13, 6:20 AMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Citizens Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth May 6, 1954 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1**√** M 2□ F Maryland 216-60-8090 50 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 and 2 should be filed within 72 hours after death with the Maryla Heelth and Mental Hyglene. Jem 27 is marked other than "natural", or itame 23a or 28e-1 ahov Wher fraumatic avent, the Madical Examinational Recording I 1XXYes 2 No Maryland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Marned Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Audrey Winpigler Donald Lee Baker, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heelth ar
Important: If Item 27 is
any injury or other trau 212 South Carroll Street, Frederick, MD 21701 Victoria J. Morgan, sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removat from State Mount Olivet Cemetery May 17, 2004 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) <sup>22.</sup> Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21. Signature of Funeral Service Licensee M00255 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-tran Due to (or as a consequence of): **Řecords, P.O. Box 68760,** Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 1 Yes 2 No Division of Vital the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3□ DOA funeral dir this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after 4 Homicide Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the within 2 29b. Signature and with of pertifier 29d. Date signed (Month, Day, Year) 29c. License number May 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederich, MO21701 SAJJAD OL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAY 2 7 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** Ovaline Alma Clausius May 13 2004 11:50 A M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner E1kton Union Hospital of Cecil County Cecil tf Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 27, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 251 46 5998 70 1933 South Carolina Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Marylend rent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural; or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 151 Stevenson Road 21901 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bart Certain Rivers Viola Jenkins 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Conrad Clausius/Son 289 Chandlee Road, Rising Sun, Maryland 21914 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or Union Cemetery <sup>¹</sup> 4 □Donation 5 □Other (Specify) May 18, 2004Elkton, Maryland 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funeral Service License 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Betw Onset and Death tmmediate Cause (Finat pulmonary **Physician** hronic obstructive resulting in death) /Medical Due to (or as a consequence of): **Examiner** Presmonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical as the tF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9☐ Unknown 9 ☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 □ No 1 Tyes of Vital To the Hospitel or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospitat Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Yeer) in by the funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After Division 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier mo werding nd address of person who completed cause of death (Item 23a) (Type, Print) 101 Colonial Way, Rising Sun, Maryland, 21914 Weidner, 32. Registrar's Signature State Registrar

			For State	State of Marylai	nd / Depa	artment rtificate	of H	ealth ai	nd Me	ental F	lygiene	20	004	16964
			Registrar  1. Decedent's Name (First, Middle, Last)		001	incare	01 2	Calli	2	2. Date of	Reg. No Death	).		3. Time of Death
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,	/Medic xamin		4a. Facility Name (If not institution, give s			4b. City, 1	Town, or	Location of				. County o	of Death	
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	neral		5. Social Security Number 6. Sex	M 2 F 7. Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	3. Date of (Month,	Birth Day, Year)		Coun	
	ector		186-38-1565 Usual Residence of Decedent	49					J	une 3	80, 19	954	Penn	sylvania
yland	N 14		10a. State 10b. County	10c. C	ity, Town or Lo	cation							10	0d. Inside City Limits
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ath w	THE STATE OF		606 Pine Road		1	207						ted S		
OU36 hours after death with the Maryland	the Modical Examinational be notified at	by Funeral	11. Marital Status  1 Never Married 2 M Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Ever in the Armed Forces?</li> <li>1 ☐ Yes 2 No If Yes, Give Year or Dates:</li> </ol>	1	Was Decede f Yes, speci 1 ☐ Yes 2	fy Cuban	spanic Origin, Mexican,  Specify:	in? (Speci Puerto Ri	ify Yes or can, etc.)	No-	14. Race Black Specify:	, White, e	etc.
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within 72 9ne.	Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of worl DO NOT use	k done du e retired)	uring most o	of working	7				,
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Physic	ion	Decedent's Name (First, Middle, La	•		•			ate of Death	Day	Year	3. Time of Dea
/Medi		LEIGHTON CAS						Month Y		2004	9:241
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Funeral Director		554-42-7742	Sex 7. Age (In yrs. 1⊠ M 2□F 69	last birthday) Yrs.	If Under 1 Yea Months Day	r If Under 24 F s Hours M	lin. (	Date of Birth Month, Day, 1 ne 15,	<sup>(ear)</sup> 1934	9. Birthpl Coun. Cali:	lace (State or Fo try) fornia
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Pe D	Director	10e. Street and Number	. л т 201		10f. Zip Code 21702			109		What Coun	
Department of Health and Mental Hygiene "natural", or Items 23a or 28a-f show Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be natified at gones.	by Funeral	90 Waverley Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?  1 XYes 2 No If Yes, Give Year or Dates: Kore			Hispanic Origin? ban, Mexican, Pu	(Specify serto Rica	Yes or No- n, etc.)	14. Ra	d State American Amer	an Indian,
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(Specify only highest grade completed)			dent's Usual Occup kind of work done	ation during most of world	16b. Kind of Bu	6b. Kind of Business/Industry			
Elementary/Secondary (0-12)	College (1-4or 5+)			•)		Garment	mana	afacturing	
17. Father's Name (First, Middle, Last	)			18. Mother's Nam	ne (First, Middle,				
Antonio Scappa		Santa Bono							
	20h Pl	ace of Dieno	sition (Name of		Date	non Landina	O1 T.	0	
1 D Burial 2 ☐ Cremation 3 ☐	Removal from State R+ Ce	Andrev Andrev	natory or other place.	ry May 24	4, 2004	Roanoke	, Vir	wn, state :ginia	
Xuhard (1	( . Parfa MOOO	21	Neeney an 106 Fast	Church St	ı runera trest F	rederic	l- MΓ	21701	
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dire to (or as a conseque	atins ofly	to their	re					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal	Live birth 2 Fetal death 3 Ectopic pregnancy  Pregnant at time of death 5 Other (specify)					23d. Date of delivery Month Day Year		
Part II. Other significant conditions of Hypertemotic	lting in the ur	nderlying cause give		acco use contribute to the cause of death?					
Hypether	Hype Plens die				24a. Was an				
110					autop perfor 1  Yes	utopsy prior to completion of cause o death?			
examiner?	Hospital: Other								
27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)								
100100111	28e. Place of Injury - At home, farm, street, factory, office 28f. Location (\$					(Street and Number or Rural Route Number, own, State)			
(Check thiny 2 Medical Exam	mmer: On the basis of examination	rledge, death	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the o	ause(s) and mai	nner as sta	ated. the cause(s)	
	and manner stated.								
> Z-y-		D00	5/21/	d. Date signed (Month, Day, Year)					
30. Name and addr- s of rson wh	m leted cause death (Item	23а) (Туре, І	Print)	E MA	2,0	<u> </u>			
2	Antonio Scappa  19a. Informant's Name/Relationship ( Linda Arme Shea  20a. Method of Disposition  1  Burial 2  Cremation 3   4  Donation 5  Other (Special Composition)  21. Signature of Funeral Service Lice  23a. Partl. Enter the disease, or composition of the shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the same of the shock or heart failure. List only Immediate Cause (Final disease or conditions are sulting in death)  Sequentially list conditions, and the same of the shock or injury that inflated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Antonio Scappatore  19a. Informant's Name/Relationship (Type, Print)  Linda Anne Shea/Daughter  20a. Method of Disposition  1	Antonio Scappatore  19a. Informant's Name/Relationship (Type, Print)  Linda Arine Shea/Daughter  20a. Method of Disposition  1	Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Forelady   Antonio Scappatore   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street Linda Arme Shea/ Daughter   14.05 Leaswing   20b. Place of Disposition (Name of the Company of the Place of Disposition (Name of the Place of Disposition (Name of the Company of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of Disposition (Name of the Place of	Forelady   Forelady   Forelady   Forelady   Transfers Name (First, Middle, Last)   18. Mother's Name Antonio Scappatore   19a. Informant's NameRelationship (Type, Print)   19b. Mailing Address (Street and Number or Ru Linda Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's NameRelationship (Type, Print)   19b. Mailing Address (Street and Number or Ru Linda Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name Relationship (Type, Print)   19b. Mailing Address (Street and Number or Ru Linda Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name And Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name And Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name And Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name Anne Shea/Daughter   1405 Leaswing Court,   18. Mother's Name Anne Shea/Daughter   1806 Leaswing Court,   1806 Leasw	Security   Security	17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Maiden Sumann Antonio Scappatore   19a. Informaria Name/Relationship (Type, Print)   1405 Leaswing Court, Frederick, Mary   1200 Mailing Address (Street and Number or Rural Route Number. City or Town, 12 Hours 1 2 Green and Scape (Street and Number or Rural Route Number. City or Town, 12 Hours 1 2 Green and Scape (Street and Number or Rural Route Number. City or Town, 12 Hours 1 2 Green and Scape (Street and Number or Rural Route Number. City or Town, 12 Hours 1 2 Green and Scape (Street and Number or Rural Route Number. City or Town, 12 Hours 1 2 Green (Number of Rural Route Number. City or Town, 12 Hours 1 2 Green (Number of Rural Route Number. City or Town, 12 Hours 1 2 Green (Number of Rural Route Number. City or Town, 12 Hours 1 2 Green (Number of Rural Route Number. City or Town, 12 Hours 1 2 Green (Number of Rural Route Number. City or Town, 12 Hours 1 2 Green (Number of Rural Route Number. 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		, 4	For State Registrar	State of Mi	arylaniu		rtificate						.2001	. 1606	7
			Registrar  1. Decedent's Name (First, Middle, I	actl		Cel	uncau	e oi L	Jeani		2. Date of De		10.C. UU 5	3. Time of Death	1
	Physici	an		atherine	Evan	s					Month	D	ay Year	N	A
	/Medic		4a. Facility Name (If not institution, g				4h City	Town or	Location of	of Death	May		.9 , 200 c. County of Dea		
	Examin	ier			чосъ	i + - 1									
	Euranal		Frederick  5. Social Security Number 6		e (In yrs. la		If Under	1 Year	eric If Under	24 Hrs.	8. Date of Bir	th	Frede	T1CK rthplace (State or Foreig Country)	n
	Funeral Director		219-64-5904	1 □ M 2 💢 F		3 Yrs.	Months	Days	Hours	Min.	(Month, Da January	y, Yea 11.	1941	Maryland	
			Usual Residence of Decedent												
	irylan show	_	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits	
	Se-1 s	cto	Maryland Frede	rick	1	reder	T			_				1√ Yes 2 No	,
	ath with the Marylan 23a or 28e-f show	Dire	10e. Street and Number				10f. Zip					10g. C	citizen of What C	country?	
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28e-f show he Medical Exami her mult be notified at	Funeral Director	1105 Key Parkway					217					U.S.A		_
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Deced If Yes, spec	dent of His cify Cubar	spanic Ori n, Mexicar	igin? (Spen, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh		
36	', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	NO		1 ☐ Yes	2₹ No	Specify:				Specify: W	hite	
8	s within 72 hours after dea liene. r then "neturel", or Items the Wedical Examiner m	ed	15. Decedent's			16a. Dece	dent's Usua	al Occupa	ation			16b.	Kind of Busines	s/Industry	_
15	n ne	Completed	(Specify only highest	grade completed)	F.\	(Give	kind of wo	rk done d	lurina mos	st of work	ing			,	
712		Eo	Elementary/Secondary (0-12)	College (1-4or	0+)	Но	memal	ker					Own H	ome	
b	be filed tal Hygid of other event,	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	er's Name	(First, Middle,	Maide			
<u>a</u>	C & e d	10 E	Dwight Mason Bla	ir					Bess	ie A	lberta	Ste	vens		
Maryland 21215-0036	d 2 should th and Men ?7 Is marke treumetic		19a. Informant's Name/Relationship	(Type, Print)			•						or Town, State,		
	t and 2 Health item 27 I		Flora Marie Evan	s/Daughter		2518	Balle	enger	Cre	ek P	ike, P.	). B	ox 212. A	damstown, MD, 217	10
Baltimore,	ges t and it of Healt if item 2 or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Removal from State	20b. Pla	netery, crei	sition (Ivan	пе от			Date	20c.	Location - City o	r Town, State	
Ĕ	Pa men ury		4 □ Donation 5 □ Other (Spe		Resth	naven M	lemoria	1 Gard	dens M	ay 2	4. 2004	F	rederic	k, Maryland	
a	permit. Departm Importe any inju		21. Signature of Funeral Service Lic	ensee	`		2. Name an			•				t Church Stree	t
Ω	Dep Imp any		7. Kyan	MI=Millia	W	Ke	eney a	nd Bas	sford	P.A.	Funeral I	Iome	Frederic	ck, MD, 21701	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused by one cause on each li	d the death. ne.	Do not ent	er the mod	le of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between	
5	Physician		Immediate Cause (Final disease or condition	Em 1	Thur.	me								Onset and Death	
	/Medical		resulting in death)	Due to (or as	a conseque	ence of):								1	
Н	Examiner		Sequentially list conditions.	b										V	
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):									
	ecute and -trans	cam	that initiated events resulting in death) Last	c Due to (or as	2 0000000114	anno of)-	- K-/								
760,	te be executed ysician and ie burial-transit		,	Due 10 (01 as	a conseque	silve oi).									
687	w > w	dicai		d											-
9 ×	The law requires that the death certificate be the has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnan	cv						- 11	23d. Date of de	alivano	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[	Ectopic pr Other (sp						Month Month	Day Year	
Ö	the de	isic	1 □ Yes 2 <del>1 No</del> 9 □ Unknown	9□ Unknown			_ O(1.0) (b)p								
P.0	res that the de igned by the a be detached		Part II. Other significant condition	s contributing to death b	out not resul	ting in the u	nderlying c	ause give	en in Part I	l.	23e. Did t	obacco	use contribute	to the cause of death?	
Records,	uires sign	d by									1 🗷	Kes :	2□No 3□P	robably 4 Unknown	١.
Ö	w require been sig	lete									24a. Was	an	24b. Were a	utopsy findings available	
Re	The lav	Completed									autor perfo	osy rmed?	prior to death?	completion of cause of	
Vital			25. Was case referred to medical						OC Diago	o of Dogti	1 ☐ Yes	2/20	lo 1  Ye	s 2 No	_
$\equiv$	Physicien: this certifica al director, p	To Be	examiner?	Hospital: 1 Inpatie	ent 2 🗆 E	B/Outnatier	nt 3 DC	Othe	or:				6 □Other (Spi	aciful	
o	<u>a</u> = <u>ra</u>		27. Manner of Death	28a. Date of Inju	ıry 2	28b. Time o		28c. Injury	at		28d. Describe			вспуј	
on	nding Pt th. : After th s funeral	tior	1 Astural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury	М	Work 1 □ Y	<pre>⟨? Yes 2□</pre>	No					
Division	Attendir death.	fice	3 ☐ Suicide 6 ☐ Could no determin	ad 200. Flace Ul III	jury - At hon	ne, farm, sti	reet, factory	, office			28f. Location (	Street a	and Number or F	Rural Route Number,	
Ö	afte Dire	Certification:	4   Homicide	building, et	tc."(Specify)						City or Tox	wn, ala	(6)		
	hours nere y fille		29a. Certifier Certifying	Physician: To the best	of my know	ledge, deat	h occurred	at the tim	e, date an	nd place,	and due to the	cause(	s) and manner a	s stated.	_
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	(Check only 2 Medicel Ex	aminer: On the basis of and manner st	ated.	on and/or in	vestigation	, in my op	oinion, dea	ath occurr	ed at the time,	date ai	na piace, and du	e to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	0			290	c. License	number			29d. D	ate signed (Mon	th, Day, Year)	
			Very the	Kurlin In	n			102	1201	1		n	es 2	1, 2004	
	100		30. Name and address of person wi	no completed cause of o	death (Item	23а) (Туре,	Print)	/			C 1		1		
	10		Lluid HA	luursin	M.	147	5 1	and	2 a	4	tule	u	h ml	21707	
• 4		ate	31. Date filed (Month, Day, Year)		rar's Signati	Ire	1	. 4	/	(					
	Regist	rar	MAY 27	2004 See	en ,	J. A	064k	9							

woisi	( )	1 - For State Registrar  1. Decedent's Name (First, Middle, Last	st)	Cei	rtificate	of Death	2. Date of Dea	-	004 69 Years 3. Time of De				
iysicia Medic	al .	Marilyn Judith E					MAY	8	2004 3:17				
camin	er	4a. Facility Name (If not institution, give Union Memorial Ho			4b. City, To	own, or Location of De Baltimore		4c. Coun	ty of Death				
neral ector		5. Social Security Number 6. S 212-24-2210	~	ast birthday) Yrs.	If Under 1 Months I		s. 8. Date of Birth	, Year)	9. Birthplece (State or Fo				
a-f show		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City L				
	Director	MD Anne Aru	ndel	Annap	olis				1 ☐ Yes 2				
or 28g		10e. Street and Number			10f. Zip C		1	0g. Citizen o	f What Country?				
al', or items 23s		3520 Cohasset Av		<u> </u>	21403	44.5	USA ace - American Indian,						
	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		was Deceder If Yes, specify 1 ☐ Yes 2	nt of Hispanic Origin? y Cuban, Mexican, Pue  nt No Specify:	Black, White, etc.  Specify: White						
edical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life.	dent's Usual ( kind of work DO NOT use	Occupation done during most of w retired)	rorking	16b. Kind of	Business/Industry				
Lie h	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)			emaker			Own Home				
	To Be C	17. Father's Name (First, Middle, Last) Roy Wilburn					ame (First, Middle, 1 Hoover	Maiden Suma	am <i>e)</i>				
treum		19a Informant's Name/Relationship (			-	Street and Number or I an Drive,							
or other	İ	20a. Method of Disposition  WX8urial 2 ☐ Cremation 3 ☐	memoval from State		sition (Name natory or oth				- City or Town, State				
njury		21. Signature of Funeral Service icensee  Crantsville Cemetery, May 12,2004 Grantsville, MD  22. Name and Address of FacilityNewman Funeral Homes, P.A.,											
any		21. Signature of Furieral Service ocer	Upmal )						mes, P.A., ville, MD 21:				
physician and in the burial-transit and in the burial-transit and in the burial-transit and in the burial-transit and in the burial-transit and in the burial-transit and in the burial transit and transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial transit and in the burial tran		23a. Part I. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Pinal disease or condition resulting in death)  a.   Due to (or as a consequence of): PERFORM EFFOSIONS  EXCURSENT PERFORMED.						Approximate Interval Betwee Onset and Dea					
	cai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):											
detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1						23d. Date of delivery Month Day Yea				
, e	by	Part II. Other significant conditions of	contributing to death but not resu	ntribute to the cause of deat									
should	etec												
page 2	e Completed	25. Was case referred to medical				26 Place of D	autops perforr 1 Nes 2	ey med? 2 □ No	. Were autopsy findings ava prior to completion of caus death? 1 Yes 2 No				
ō	OB	examiner?						ome 5 ☐ Residence 6 ☐ Other (Specify)					
	n: T	27. Manner of Death Natural 5 Pending	28a. Dite of Injury (Month, Day Year)	28b. Time of Injury	280	. Injury at Work?	28d. Describe ho	28d. Describe how injury occurred					
eral d	atio	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M eet, factory, o	28f. Location (St City or Town	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
eral d	ertific		29a. Certifier  (Check only (Check only and place) and due to the cause(s) and manner as stated.  29a. Certifier (Check only (Check only and place) (Check only (Check only and place) (Check only (Check only and place) (Check only (Check only (Check only and place)) (Check only (Che										
eral d	dical Certification:	29a. Certifier (Check only one) (Check only one)	niner: On the basis of examinat	wiedge, deati tion and/or in	n occurred at vestigation, in	my opinion, death oc	curred at the time, d	ate and place	, and due to the cause(s)				
	Medical Certific	(Check only 2[ Medical Exam	nysician: To the best of my knorniner: On the basis of examinat and manner stated.	wiedge, deati	vestigation, ir	n my opinion, death occurrence number			ed (Month, Day, Year)				
eral d		(Check only 2[ Medical Examone)	niner: On the basis of examinat	ion and/or in	29c. I	n my opinion, death occurrence number			, and due to the cause(s)				

RKD			1 - For Stete Registrar		ryland / Depa	artment of Heartificate of De	alth and M	lental Hygi		0 0 4	16969	
>	Physic /Medi Exami	cal.	1. Decedent's Name (First, Middle, Las Kenneth C. A 4a. Facility Name (If not institution, give	riant		4b. City, Town, or Lo	ocation of Death	2. Date of Death Month MAY			3. Time of Death 4:52P. M	
	Funeral Director	lei	9315 Creek Lane		(In yrs. last birthday)  5 3 Yrs.	CHESTERT		8. Date of Birth (Month, Day, Aug 26	KENT	9. Birthp	lace (State or Foreign htty), Mb e.n.15 u.n.9,	
	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be rotified at once.	ector	Usual Residence of Decedent  10a. State  10b. County  MD  Kent		10c. City, Town or Lo	ntown				0d. Inside City Limits 1 N Yes 2 □ No		
9036		d by Funeral Director	10e. Street and Number  93/5 Creek Lar  11. Marital Status  1 Never Married XXMarried  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:	D I	10f. Zip Code  2/620  Was Decedent of Hispa f Yes, specify Cuban, f			14. Rac	USA e - Americ ck, White,	an Indian,	
nd 21215-0036		Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) / 2 17. Father's Name (First, Middle, Last)	de completed) College (1-4or 54	(Give	dent's Usual Occupation kind of work done during the NOT use retired)  Employed	ing most of workii	ng	Cabine	Kind of Business/Industry  binet Maker  an Sumame)		
Σ		Tof	9 John L. Friant  19a. Informant's Name/Relationship (Type, Print)  Cynthia A. Friant / Spouse 93/5 Creek Lane Chestertown, MD									
Baltimore,			20a. Method of Disposition  XBurial 2 □ Cremation 3 X  '4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	)	Mt Nebo	sition (Name of natory or other place)  //. M. Com . Name and Address of ee A. Patterryville,	5/20 of Facility terson &	/2004 #	eral Ho	one.	PA 17532	
	nysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Hony	he death. Do not ento to consequence of):	er the mode of dying, s	such as cardiac o	r respiratory arres	st,		Approximate Interval Between Onset and Death	
	ate be executed hysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	c	consequence of):							
.O. Box 68	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of deliver	Y Day Year	
ords, P	The law requires that the ite has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the ur	derlying cause given in	n Part I.	23e. Did toba	. /		e cause of death?	
		e Completed	25. Was case referred to medical			26	3. Place of Death	24a. Was an autopsy performe 1 Ves 2 (Check only one)	ed? d	rior to com eath?	sy findings available ipletion of cause of	
Division of	Attanding Physical death, teles the funeral distribution of the funeral distribution o	ertification; To B	examiner?    X Yes 2 No	building, etc.	28b. Time of Injury 4.30 y - At home, farm, stre (Specify)	3 DOA Other: 28c. Injury at Work? 1 Yes	4 Nursing Hom 2 2 No 2	Bd. Describe how is a constitution of the cons	ce 6 XOther injury occurred to the injury occ	ed L C D er or Rural	SELF  Route Number. WD	
	the Hospita hin 24 hours tha Funaral hpletely filler	Medicai Ce	one) Medicel Exam	sicien: To the best of ner: On the basis of e and manner state	my knowledge, death	occurred at the time, destigation, in my opinion	date and place, a on, death occurre	nd due to the cau d at the time, date	se(s) and mar and place, a	nner as sta nd due to t	the cause(s)	
<b>)</b>	S To Mith	V	29b. Signature and title of certifier  30. Name and address of person who c	The JA		Print)	C.ME	MA	Date signed	004		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 200	32/Aegistrar		111 Penn St	treet, B	altimore	, Mary	Land	21201	

		1 - For State of Registrar	Maryland / Dep	artment of Health and rtificate of Death	Mental Hy			
Physicia /Medic Examin	cal	1. Decedent's Name (First, Middle, Last)  THOMAS WILLIAM FORD, SR. 4a. Facility Name (If not institution, give street and num  6735 FRIENDLY OAK PLACE		4b. City, Town, or Location of Deat	2. Date of Dea Month MAY	ath Day Year 13, 2004 10:23 F  4c. County of Death CHARLES		
Funeral Director		5. Social Security Number  214-28-7655  Usual Residence of Decedent	7. Age (In yrs. last birthday, 79 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birt (Month, Day OCTOBER	h 9. Birthplace (State or Fore Country)		
the Maryiar 28a-f show cutilied ■	Director	MARYLAND CHARLES  10e. Street and Number	BRYANS R			10d. Inside City Lim 1    Yes 2   10g. Citizen of What Country?		
18 23a or		6735 FRIENDLY OAK PLACE	20616 UNITEI			UNITED STATES		
72 nous aner deam with the Maryland naturat', or Items 23e or 28e-f show digal Examiner must be notified at	d by Funeral	1 Never Married 2 Married 1 Yes, Giv. 3 Widowed 4 Divorced Year or Da	2 (ANO e ites:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	to Rican, etc.)	Black, White, etc.  Specify: BLACK		
within ene. than	Completed	15. Decedent's Education (Specify only highest grade completed)  TH GRADE  15. Decedent's Education (Give kind of work done dulifie. DO NOT use retired)  EXPLOSIVES OPER					16b. Kind of Business/Industry  FEDERAL GOVERNMENT	
Department of Health and Mental High Department of Health and Mental High Important: If item 27 is marked other; any injury or other traumatic event, I once.	To Be C	17. Father's Name (First, Middle, Last) WILLIAM JOSEPH FORD		ANTIONET	TE JENKI			
		19a. Informant's Name/Relationship (Type, Print)  ANTHONY FORD / SON  20a. Method of Disposition	3512 S	ng Address (Street and Number or Au SILVER PARK DRIVE, #5.				
		1 M Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  LEON THORNTON MO0582	HOLY GHO	matory or other place) ST CHURCH CEM. MA Name and Address of Facility HORNTON FUNERAL H				
hysician physician and physician and physician and physician and the prijal-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	used the death. Do not ent ich line.	ter the mode of dying, such as cardiac EFC CHWCH DATHIELD MANUCINAL  CINCLE	or respiratory arr	Approximate Interval Between Onset and Death Onset Approximate Approximate Interval Between Onset and Death Onset Approximate Approximate Interval Between Onset and Death Onset Approximate Interval Between Onset and Death Onset Interval Between Interval Between Interval Betwee		
ed by the attending ph detached for use as th	Physiclan/Med	in the past 12 months?	int at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day			
ite has been signed by	þ	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given in Part I.		bacco use contribute to the cause of death?		
	e Completed	OF Wassess of an advantage of a state of a s				prior to completion of cause death?  Yes 2 No		
this aldi	To B	27. Manner of Death  1 Satural 5 Pending (Month) 2 Accident investigation	patient 2 ER/Outpatier finjury n, Day Year)  28b. Time of Injury	nt 3 DOA Other: 4 Nursing H		ence 6 □Other (Specify)  ow injury occurred		
within 24 hours after death.  To the Funeral Director: After completely tilled in by the funeral	al Certification:	29a. Certifier 15 Certifying Physician: To the	of Injury - At home, farm, str g, etc. (Specify) pest of my knowledge, deat	n occurred at the time, date and place	City or Town	gues/s, and mapper as stated		
within 24 h To the Fu	Medical	29b. Signature and title of certifier	sis of examination and/or in	29c. License number	rred at the time, d	ate and place, and due to the cause(s)  9d. Date signed (Month, Day, Year)		
) 4 Sta	te	30. Name in address if per on who completed cause 31. Date filed (Month, Day Year) 7 2000	of death (Item 23a) (Type,	Print) mn, \	JALT	oper, milze		

	1 - For Stata Ragistrar		artment of Health and Nertificate of Death	Reg. No.	2004 1697
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last,  Constance E.  4a. Facility Name (If not institution, give  220 W. High St  5. Social Security Number  6. Sec	Ganzman street and number)  7. Age (In yrs. last birthday	4b. City, Town, or Location of Death E1kton	8. Date of Birth (Month, Day, Year)	County of Death  Cecil  9. Birthplace (State or Foreign Country)
death with the Maryland ms 23a or 28a-f show rimust be rollified at the maral Director	Usual Residence of Decedent   10a. State   10b. County   MD   Cecil   10e. Street and Number   Cecil	10c. City, Town or L	n 10f. Zip Code	April 24	10d. Inside City Limits 1 X Yes 2 □ No izen of What Country?
urs after al', or Ite marrine by Ful	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto December 2 No. Specify:  edent's Usual Occupation a kind of work done during most of work	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White  nd of Business/Industry
be fited within that Hygiene. In other than event, It a My	17. Father's Name (First, Middle, Last) Unknown	College (1-4or 5+) ASSE	mbly Line Repairs Marie	ir Ro e (First, Middle, Maiden e Pease Re	eed
permit. Pages 1 and 2 should popartment of Health and Met Importent: If item 27 is market any injury or other treumatic gonce.	19a. Informant's Name/Relationship (T)  Clarence L. Gan  20a. Method of Disposition  1 Burial A Cremation 3 F  4 Donation 5 Other (Specify)	nzman, Sr./Hus.  20b. Place of Disp cometery, cre  R.A. Fe	220 W. High Sostion (Name of imatory or other place)  27. Name and Address of Facility  Andrew G. Gee H	E1kto 20c. Lo 18, 2004	on MD 21921 cation - City or Town, State  West Chester,
The law requires that the death certificate be executed XIII XIII XIII XIII XIII XIII XIII XI	shock, or Neart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Tailyre	F1ktC	Interval Between onset and Death
w requires that the death certifical been signed by the attending pt should be detached for use as it and the bear that the province of the pr	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
: The law requires that cate has been signed b page 2 should be deta Completed by PP	Part II. Other significant conditions con	ntributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco u  1  Yes 2  24a. Was an autopsy	se contribute to the cause of death?  No 3 Probably 4 Dunknown  24b. Were autopsy findings available prior to completion of cause of
ng Physician: fler this certific ineral director. on; To Be C	25. Was case referred to medical	Iospital: 1 Inpatient 2 ER/Outpatie  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At home, farm, st building, etc. (Specify)	nt 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work?  M 1 Yes 2 No	performed?  1 Yes 2X No  h (Check only one)  me 5 X Residence 6 28d. Describe how injury	death? 1 Yes 2 No  G Other (Specify) y occurred d Number or Bural Route Number,
To the Hospitel or Attending within 24 hours after death To the Funerel Director: After completely filled in by the fune Medical Certification	(Check only 2 ☐ Medicel Examione)  29b. Signature and title of certifier	alcien: To the best of my knowledge, deal ner: On the basis of examination and/or in and manner stated.	29c. License number  DOUS 9304	red at the time, date and	and manner as stated. place, and due to the cause(s) e signed (Month, Day, Year)
State Registrar	30. Name and address of person who con the person who continued the person who contin	mpleted cause of death (Item 23a) (Type	St. Suik 314	Elkten,	10 21921

		For Stete Registrar	State of Maryland		ent of Health and ate of Death	Mental Hygier		1697	
Physicia /Medica Examina	in al	Dorothy Alice      A. Facility Name (If not institution, give	Gank	4b. Ci	ty, Town, or Location of De	May 11	Day Year L. 2004 4c. County of Death	3. Time of Death	
Funeral Director		213-10-5402			Oakland der 1 Year   If Under 24 Hi	rs. 8. Date of Birth	Ga) 9. Birth	rrett place (State or Fore ntry) ryland	
ath with the Maryland 123a or 28a-f show		Usual Residence of Decedent           10a. State         10b. County           MD         Gar           10e. Street and Number	10c. City, Trett	Fown or Location	Oakland Zip Code	10g. (	10d. Inside City Li 1 ☐ Yes 2 ½		
urs after de al', or items	d by Funeral Director	84 Cozy Pine Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		2155 cedent of Hispanic Origin? ( becity Cuban, Mexican, Pue		USA  14. Race - Ameri Black, White,  Specify: W		
within iene. than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 8th	cation (a completed) College (1-4or 5+)	16a. Decedent's U: (Give kind of v life. DO NOT	work done during most of w	orking 16b.	Kind of Business/in	dustry	
even	To Be	17. Father's Name (First, Middle, Last)  Henry  19a. Informant's Name/Relationship (T)	Steid		18. Mother's Na Anna ass (Street and Number or F	ame (First, Middle, Maid	Her	rman o Code)	
it. Pages 1 and 3 treet of Health reent of Health reent: If item 27 njury or other treet.	4	Inise Bell/daught  20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	Removal from State Garre	e of Disposition (A etery, crematory of ett Co. M	f other place)  Iem. Gdns. 5	Date 20c.	Location - City or To	aryland	
nysician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. In the cause on each line.	Do not enter the m	Second St.,	Oaklnad. M	d. 21550	Approximate Interval Between Onset and Death 3 Weeks	
ysicia	icai Exar		b. atheroscler Due to for as a consequent c. CONGESTIVE Due to for as a consequent d.	heart		ar diseas		yrs 2 yrs	
ite has been signed by the attending phoage 2 should be detached for use as it	/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 No 9 □ Unknown	:3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 □Ectopic			23d. Date of delive Month	ery Day Year	
engi be d	` ה	Part II. Other significant conditions con history of cere					use contribute to the		
is certificate has bo director, page 2 st	e Completed	25. Was case referred to medical				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	prior to cor death?	psy findings availampletion of cause	
r death. ector: After this certifice by the funeral director, i	0	examiner? 1	The state of the s	Outpatient 3 C b. Time of Injury	Other	ath Check only one)  Home 5 Residence  28d. Describe how injuge.	sidence 6 Other (Specify)		
ret Dir	al Certification:	3 Suicide 4 Homicide  Could not be determined	28e. Place of Injury - At home building, etc. (Specify)			28f. Location (Street a City or Town, State	te)		
E = > 1	Medical	(Check only 2 Medicel Exemile one)	ner: On the basis of examination and manner stated.	and/or investigation	o at the time, date and place on, in my opinion, death occi	urred at the time, date ar	s) and manner as st nd place, and due to ate signed (Month, I	the cause(s)	

		1. Decedent's Name (First, Middle, Las-	t)				2	. Date of De. Month		Year	3. Time of Dea
Physici /Medic		Paul Eric	ch Grundma	an			1	April		04	7:40A
Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, T	Town, or Location of	of Death		4c. County o	f Death	
		Caroline Nursin				nton 1 Year   If Under	24 Hrs.   0	Date of Dis	Caro		
Funeral		5. Social Security Number 6. Se	ex /.Agei(// DXM 2□F	n yrs. last birthday Yrs.		Days Hours	Min.	Date of Bin (Month, Da	y, Year)	Count	
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yland		10a. State 10b. County	10	c. City, Town or I	Location					10	Od. Inside City Li
Mar a-fet	tor	Maryland Carolin	e	Denton	1						1 ☐ Yes 2 💆
th the or 28	Director	10e. Street and Number			10f. Zip (	Code			10g. Citizen of W	hat Coun	try?
itied within 72 hours after death with the Maryland Hygiene. Hygiene. Ather than "natural", or teme 23a or 28a-f ehow inter than "natural", or teme frout be notified at out, the Macietal Exeminer frout be notified at		8965 Double Hi	lls Road			21629	0.0	/ N	United		en Indian.
er de	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13	If Yes, speci	ent of Hispanic Ori ify Cuban, Mexicar	gin? (Specii n, Puerto Ric	can, etc.)		, White,	
Defitition (e), Man yianing Z. L. L. C. Cooper, Service at Section 2 should be filed within 72 hours att Department of Health and Mental Hygiene.  Moortant: If item 27 is marked other than "netural", or in my injury or other traumatic event, Ita M. Mical Examinance.	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 MNo If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:			Specify:	casia	an.
2 hou	ted	15. Decedent's Ed		16a. Dec	edent's Usual	Occupation	a of modelno		16b. Kind of Bus		
hin 7:	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	k done during mos e retired)	t or working				
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be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)		-		,			Maiden Sumame	)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatile and Mental Hygiene. Important: If item 27 is marked at the than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Machinal Examinal must be natified at once.	ို		Gerhardt Gr		Han 644			Schleb		tate 7	Code
l 2 sh n and r is rr raurr		19a. Informant's Name/Relationship (7							er, City or Town, S		
Health Pm 27 ther 1		Norma M. Grundman  20a. Method of Disposition		20b. Place of Disp	position (Nam	e of	Road, Dat	Dento	n, Maryla 20c. Location - C	ind 2	wn, State
nt of		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	St. John's	ematory or oth Luthera	an Church	MAY 03	2004	Westmins	tor	Marula
it. P.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Calerar	Y	d Address of Facilit		2001	Wesculling	cer,	Maryra
Depa Impo eny ii		Luckelli	Plocy		Moore Fi	neral Home	P A	ot D	onton M		
Physician		23a. Part1. Enter the disease, or composite shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the one cause on each line.	e death. Do not e	inter the mode	th Second of dying, such as	cardiac or r	espiratory a	rrest,	11. <u>Y</u> 1.6	Approximate Interval Between
Physician //Medical Examiner percentage prize of the priz	cal Examiner		b	e death. Do not e  Onsequence of):	inter the mode	th Second of dying, such as	cardiac or r	espiratory a	rrest,	7	Approximate Interval Between
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State of Maryland / Department of Health and Mental Hygiene 2 () () []

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Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 21, Day 200 4 ear **Physician** 9:47 AAM CHARLES KENNETH HAINES /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL 726 WARFIELDSBURG ROAD WESTMINSTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year JUNE 1, 19 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days **Funeral** 1√2 M 2□ F 216-22-1968 75 Yrs. MARYLAND Director Usuel Residenca of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County show ed other than "natural", or Items 23s or 28s-f show avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director WESTMINSTER MARYLAND CARROLL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 726 WARFIELDSBURG ROAD 21157 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: by WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other then CARPENTER UNION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be EDWARD THORTON HAINES VIOLET MARIE GIST 2 of Heelth and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY H. HAINES/WIFE 726 WARFIELDSBURG RD, WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 5/24/2004 permit, Peges 1 Department of H Important: If Ita any injury or ot Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. PAUL'S LUTHERAN CEMETERY UNIONTOWN, MD 21158 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HURO MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTFR, 21157 23a. Pert1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final carcinoma with metest Renal **Physician** resulting in death) /Medical Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed the attending physician and hed for use as the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Deen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: After Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the 1 within 24 hours after deat To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital peril Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completaly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier vormele D23443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. NAYAN VAYWALA 1130B BALTIMORE BLVD, WESTMINSTER, MD 21157 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

			for State Registrar	State of Maryland	d / Depa <i>Ce</i>	artment of H	lealth and Death	Mental Hygier	ne 200	4 16975		
			Decedent's Name (First, Middle	, Last)				2. Date of Death		3. Time of Death		
	Physici /Medic		Veronica Inez H	ahn					Day Year 2004	3:50 P M		
N. Contraction	Examir		4a. Fecility Name (If not institution,	, give street and number)		4b. City, Town, or	Location of Dear		4c. County of Dea	7,70		
			Kline Hospice H	ouse		Mt. Airv		F	rederic	5		
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. I.	ast birthday)		If Under 24 Hrs Hours Min	8. Date of Birth	9. Bi	rthplece (State or Foreign country)		
к	Director		214-10-3817	1 M 2 M F 88	Yrs.	Months Days	110013		0	yland		
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits		
	Aaryli Feho	៦	Maryland Freder							1 ☐ Yes 2 No		
	the 1	Director	10e. Street and Number	ick rrede	erick	10f. Zip Code		100	Citizen of Whet C			
	with be or			1 -						ountry		
	leath	Funeral	10085 Quail Kno	D Lane 12. Was Decedent Ever in U.S	5. 13.	21702 Was Decedent of Hi	spanic Origin? (5	USA	14. Race - Am	erican Indian		
(0	r ker	Fun	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? ied 1 ☐ Yes 2XXVo		II Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, Whi			
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Hems 23a or 28a-f show ta Medical Exercitaer next be notified at	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2/CXNo	Specify:		Specify: Wh	nite		
9	72 ho	Completed	15. Decedent' (Specify only highest		16a. Dece	dent's Usual Occupa	ation	16b.	Kind of Business			
2	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	) )	rking				
7	ed wi	Con	7		Cler	k			etail			
Maryland	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, L	_ast)			18. Mother's Na	me (First, Middle, Maid	en Sumame)			
<u>X</u>	Meni Meni arke	70	Elmer C. Stup					la Babbingt				
Jar	2 sh and ls m		19a. Informant's Name/Relationsh					ural Route Number, City		Zip Code)		
	and lealth m 27 her t		Wanda Jean Thron				ob Lane,	Frederick	•	702		
0	or of		20a. Method of Disposition 1 ☐ Burial 2 X Cremation		ace of Dispo metery, crer	sition (Name of matory or other place	9)	Date 20c.	Location - City or	Town, State		
Ē	Pa tmen tant: jury		*4 □Donation 5 □ Other (Sp	pecify) Smi		cg Cremato				, Maryland		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic svent, its Medical Exercitivative rediffied at once.		21. Signature of Funeral Service L	. K	22	2. Name and Addres	s of Facility Ke	eney and B	asford F	uneral Home		
	40240	1	yan M.	Deign MOOS				reet, Fred	erick, M			
				complications that caused the death. only one cause on each line.	. Do not ent	er the mode of dying	J, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)  Ovarian Cancer  14									
	/Medical Examiner	Due to (or as a consequence of):										
100		er	Sequentially list conditions.		Years							
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ŏ	death certifi e attending od for use as	ZW.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan					23d. Date of de	livery		
ň	death a atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Fetal of 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year		
o.	by the de	hys	9 Unknown	9□ Unknown								
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<u>8</u>	w require been sig should b							1 Tes	2 <b>∑</b> No 3 □ Pr	obably 4 Unknown		
Records,	law re as bee 2 sho	Completed						24a. Was an	24b. Were au	utopsy findings available		
	sician: The la certificate has rector, page 2	ШО						autopsy performed? 1 ☐ Yes 2 ☑ N	prior to	completion of cause of		
Vita	an: tiffica tor, p	Ф	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes 2 ♣ N	to 1 Tes	2 No		
	Physician: this certific ral director,	OB	examiner? 1 ☐ Yes 2 🂢 No	Hospital:	R/Outpatien	t 3 DOA Othe			6 XIOther (Sne	chy)Hospice Hou		
OI	g Physier this	n: T	27. Manner of Death	28a. Date of Injury	28b. Time of		at	28d. Describe how inj		on nospice nous		
<u>o</u>	Attending I r death. actor: After by the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga		injury		es 2 🗆 No					
DIVISION	al or Atteno after death Diractor: d in by the	ii	3 Suicide 6 Could no 4 Homicide determin		ne, farm, stre	et, lactory, office		28f. Location (Street a		ural Route Number.		
5	s afte	Certification:		building, etc. (Specify)				City or Town, Sta	110)			
	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier (Check only 2 ☐ Medical E	Physician: To the best of my know xaminer: On the basis of examination	ledge, death	occurred at the time	e, date and place	and due to the cause(	s) and manner as	stated.		
	the H iin 24 the F the F	ledical	one)	and manner stated.	on and/or inv	estigation, in my op	nion, death occu	rred at the time, date ar	nd place, and due	to the cause(s)		
	To To Con	Σ	29b. Signature and title of certifier	1/2/	14 0	29c. License			ate signed (Mont			
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	(0			who completed cause of death (Item :								
	Υ			, MD, 1475 Taney		e, #204,	Frederio	k, Marylan	d 21702			
	Sta		31. Date liled (Month, Day, Year)	32. Registrar's Signatu	Çθ	is for	20 27 -					
	Registra	all .		MAY 2 7 2004 A	All Collins	15 600	1000					

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,	Physici /Medic		1. Decedent's Name (First, Middle,	Ho		(12)5					2. Date of De Month	Day	2004	3. Time of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution,  5. Social Security Number  212–32–5496	5 Wosp 6. Sex 7. Ag	of to	last birthday) Yrs.	4b. City,  5 / /  If Under  Months	lue	If Under 2	DV/C	8. Date of Bir (Month, De May 27	th v. Year)	91 Sirthp	lace (State of Foreign thry)
Baltimore, Maryland 21215-0036	permit. Pages t and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination and Department by notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  14819 Harold  11. Marital Status  1 Never Married  2 Married  (Specify only highest  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, L.  John  19a. Informant's Name/Relationshi  Wanda W. Hopk:  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Specify County)  21. Signature of Funeral Service Married	Road  12. Was Decedent Amed Forces? 1	S S Ever in U. No  5+)  120b. Pa Pa	16a. Decec (Give life.) Stee 19b. Mailir 1481 1ace of Dispo emetery, crer rklawn	Sprin 10t. Zip 200 Was Deceder Yes, spec to	Code  2005  Ident of History Cubar  22 No  al Occupar  Ark done de  crker  (Street a  rold  me of  ther place  ttery  and Address  Old	specify:  tion uring most  18. Mother  Road  M  S of Facility  Alex	rs Name Edit r or Rural Silv Da lay 1 y Le	(First, Middle, h  Route Numbiner Springer) 9,2004 e Funeria Ferri	U.  16b. Kin  Beth  Maiden S  J  er, City or  ing,  20c. Loc  Roc  ry RD	en of What County S.A.  4. Race - America Black, White, Specify: Black d of Business/Inco  1eham St  Sumame) ones Town, State, Zip Marylance ation - City or To kville, ome, inc	an Indian, etc. ack dustry teel  code) d 20905 wn, State Maryland con, MD 20735
760,	Physician /Medical Examiner partial-transit	ical Examiner	23a. Part1. Enter the disease, or cannot shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as Due to (or as d.	a consequence a consequence co	uence of):	er the mod	e of dying	bol bol pgl	cardiac or	respiratory a	C		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal	Ideath 3	Ectopic pr					23	Bd. Date of delive Month	ry Day Year
<b>a</b>	w requires that t been signed by should be detac	by	Part II. Other significant condition	s contributing to death t	out not resi	ulting in the u	nderlying c	ause give	n in Part I.	-		obacco us Yes 2		e cause of death?
Vital Records,		e Completed	25. Was case referred to medical						26 Dina	of Dooth	24a. Was autor perfo 1 Yes	osy rmed? 2 No		osy findings available inpletion of cause of
Division of Vil	ling Phys	To B	examiner?  1 No 2 No  27. Manner ol Death  1 Natural 5 Pending investigs	ation	ury	ER/Outpatier 28b. Time of Injury		28c. Injury Work	at A □ Nui	rsing Hom		dence 6	Other (Specify occurred	)
Divis	To the Hospitel or Attent within 24 hours after death To the Funaral Director: completely filled in by the	i Certification:									vn, State)			
	To the Hos within 24 ho To the Fun completely I	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examina tated.	tion and/or in	vestigation	, in my op	inion, deat	th occurre	d at the time,	date and p	place, and due to	the cause(s)
	F > F 0		30. Name and address of person w	who completed cause of	death (Item	23a) (Tyne	Print)	000	2101	ment	1con 1	Max	114	2004
M	P 10 Sta Regist		JRA N 1	7 2004 32. Rough	rar's Signa	mo ture	doors	NE	5,,	hve(	Spri	7, 5	nb 209	2004- 2004- 302

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and N Certificate of Death		giene Beg. No:?○ ∩ (	1.6077		
			Decedent's Name (First, Middle, Last)	2. Dete of Dee	eth CU	3. Time of Death		
-	Physici /Medio		MILLARD LOUIS HASENBUHLER	MAY 8,	2004	10:05 AM		
J. J.	Examir	er	4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Li	ocation of Death				
_	Funeral		DENNETT ROAD MANOR NURSING HOME  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	GARRE	9. Birthplace (State or Foreign Country)		
п	Director		710-09-5655 1\(\frac{1}{3}\)M 2□ F 92 Yrs. Months Days Hours Min.	8. Date of Birt (Month, De) NOV 7,	1911	MARYLAND		
	wa ma		Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits		
	death with the Marylend orns 23s or 28s-f show if must be northed at	tor	MD ALLEGANY CUMBERLAND		1 ŽŽYes 2 □			
	or 28s	Sirec	10e. Street end Number 10f. Zip Code		10g. Citizen of W	. Citizen of Whet Country?		
	e 23a	ral	1826 FREDERICK STREET 21502	anifu Van an Na	US.	A - American Indian,		
_	r Rem	by Funeral Director	1 Never Married 2 Married 1 X Yes 2 No	s? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ No				
% 07 07	ours a	by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates: WW II □ Yes 2 X No Specify:		Specify:	WHITE		
5-(	filed within 72 hours after Hygiene. ther then "naturel", or fte ent, the Medical Examine	Completed	15. Decedent's Education (Specify only highest grade completed)  16e. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Bus	iness/Industry		
212	iene. then	E O	Elementery/Secondary (0-12) College (1-4or 5+)  12 ACCOUNTANT		RAI	LROAD		
멀	be filed Ital Hyg of other event,	Be C	17. Father's Neme (First, Middle, Last)  18. Mother's Name	e (First, Middle,	Maiden Sumame	)		
yla	should b ind Ment imarked umatic e	2	HARRY FRANCIS HASENBUHLER LULU			OORE		
Maryland 21215-0020	C/ # = 0		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rur</i> DORIS GOLDSBOROUGH - NIECE  1210 BROADFORD ROAD		LAND, MD			
	s 1 and of Haalth item 27 other tr	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State		
<u>E</u>	Pages ment of l		1 □XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HILLCREST MEMORIAL PARK 5	/11/04	CUMBERLA	ND, MD		
Baltimore,	permit. Departr importu any inji		21. Signature of Funaral Service Licensee 22. Name and Address of Facility	P.O.	BOX 243			
_	40264		MODIE MODIES FUNERAL HOME		NAME OF TAXABLE PARTY.			
1	Physician		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on eech line.	or respiratory ar	rest,	Approximate Interval Between Onset end Death		
7	/Medical		Immediate Cause (Final disease or condition acute cerebrovascular accident			2 weeks		
	Examiner	_	resulting in death)  Due to (or es a consequence of):					
	ted nsit	mine	Atherosclerotic cerebrovascular dis	ease		2 years		
o,	ficate be executed g physician and as the bunal-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying					
68760,	ate be hysici the bu	dical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
	certific iding p		d					
8	death death death	Iclar	Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I.	23b. Did to	obacco use cont	ribute to the cause of death?		
Division of Vital Records, P.O. Box	et the d by the etache	Physician/M	impaired glucose tolerance	1 🗆 1	es 2 🗓 No	3 ☐ Probably 4 ☐ Unknown		
S)	iras th signed d be d	1 by		24a. Was a	n nutonou	24b. Were autopsy findings		
000	v requ	Completed by		perfor	med?	available prior to completion of cause of death?		
H.	he lav te has ege 2	d mo		104	es 2XNc .	1 ☐ Yes 2 ☐ No		
ita	lan: T	BeC	25. Was case referred to medical examiner?	h (Check only o	ne)			
5	hysic his ce al dire	유	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho		ence 6 □Other			
ouo	ding P. h. After t	Certification:	27. Manner of Deeth  1 Naturel 5 Pending 28a. Date of Injury (Month, Dey Year)  28b. Time of Injury Work?  1 No Yestigation  28c. Injury at Work?  1 Yes 2 No	28d. Describe n	ow injury occurre	ď		
Nisi Visi	Attender deat ector:	Iffica	a Downth S Could not be	28f. Location (S City or Tow	treet and Number	r or Rural Route Number,		
ā	its after or self or s	Cer						
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending completaly filled in by the funeral director, pege 2 should be detached for use as	Medical	29a. Certifier  (Check only one)  Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date end place, consider the time of the basis of examinetion end/or investigation, in my opinion, death occurred and manner stated.	and due to the c red et the time, o	euse(s) and man late and place, ar	ner es stated. ad due to the cause(s)		
	Vithin Fo the	M	29b. Signature end title of pertifier 29c. License number	2	29d. Date signed	(Month, Day, Year)		
			Marsan MD Doo25759		May 9,	2004		
			30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Walter K. Naumann, M.D., PO Box 247, Accident MD 2152	0				
	Sta	te	31. Dete filed (Month, Day, Year)  32. Registrer's Signature					
	Registr	_	MAY 1 0 2004 See & Seek					
	MH 16 Day 660	_						

DHMH 16 Rev 6/95

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 AMEND TIEM #9 PER FH C831 5/28/04 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 10:05 pm cona 04 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) arrol Lorien Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Min. 1 □ M 2 EXE Months Deys Hours Yrs. 213-42-5028 MISSOURI Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Midway Avenue Apt. 224 21771 United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) William Ziegenmever Meta Hansen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Douglas Hinely/ Son 18813 Muncaster Road, Rockville, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 5/8/2004 Olney, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Olin L. Molesworth P. A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Pert1. Enter the disease, or complic to a stat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) SYST DISEASE AMERICALE NOTE CAMPIONAS CULAR 10 4 EAR Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unitnown HBM WATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed?

Physician /Medical Examiner

or Attending Physician: The law requires thet the deeth certificete be executed

this certificete

**Director**:

within 24 hours effer To the Funeral Dire

of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

10a State

Directo

by Funeral

Be Completed

Examiner

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ita Medical Evandrer must be notified at

Maryland 21215-0020

Baltimore,

Completed

Physician/Medical Examiner

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Be

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edical Certification:

2/2110 1 TYUS

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

examiner?	
27. Menner of Death	5 Pend

2 Accident

3 ☐ Suicide

4 Homicide

28e. Date of injury (Month, Day Year) 5 Pending investigetion

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

Other: 4 Jurising Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a. Certifier (Check only one) 29b. Signature end title rtifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my oninion, death accurred at the time, date and place, end due to the cause(s) and manner as steted. ner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ND 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

end manner stated.

21762 FAEDE MILL mD

• State Registrar

31. Dete filed (Month, Day, Year)

NUIO MENOCEN MI

154 opossum rown 32. Registrar's Signature

29c. License number

			For State Registrar	ease			nd / Dep	artment of	Health	and M	ental Hy	giene		
							<i>Ce</i>	rtificate o	Deali				2004	15979
	Physici /Medio		1. Decedent's Name (First, Name Tanet Ruth J								2. Date of De Month May	Day 12	2004	3.1 ime of Beath 3
7	Examin		4a. Facility Name (If not instit	ution, giv	e street and nur	nber)		4b. City, Town,	or Location	of Death			ounty of Death	
П			Union Hospit	al				Elktor				С	ecil	
	Funeral Director		5. Social Security Number 210-30-5350		Sex 1□M 2⊠F	7. Age (In yr	s. last birthday)	If Under 1 Yea Months Day		Min.	8. Dete of Bir (Month, Da ebruar	y, Year)	Cou	place (State or Foreign intry) PA
	and **		Usual Residence of Deceden 10a. State 10b. Co			10c. 0	City, Town or Lo	ocation						10d. Inside City Limits
	f sho	0	MD Ce	cil			Rising	Sun						1 ☐ Yes 2 🕱 No
	the 28a	rect	10e. Street and Number	2/1/2			re-o-entg	10f. Zip Code			-	10g. Citize	in of What Cou	intry?
	3e of		201 McNamee					2191	1			USA		
	ms 2	Jera	11. Marital Status		12. Was Dece	edent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic O	rigin? (Spe	cify Yes or No	o- 14	. Race - Ameri Black, White	
21215-0036	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. It is marked other than "netural", or items 23e or 28e-f show treumatic event, it a Medical Example must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo		1 Tes If Yes, Giv Year or D	2 <b>X</b> No ∕e		1 ☐ Yes 2X N			rican, etc.)		pecify: Wha	
9	72 ho	ted	15. Dece	dent's E	ducation ade completed)		16a. Dece	dent's Usual Occ	upation	st of workin	20	16b. Kind	of Business/Ir	ndustry
21	thin 7	ple	Elementary/Secondary (0-		College (	I-4or 5+)		kind of work don DO NOT use reti	red)	or or mornin	<b>'9</b>		4.	
21	filed with! Hygiene. other than	Completed	12				Вос	kkeeper	1 45 14 11		/=		ounting	3
nd	be filly d oth	Be	17. Father's Name (First, Mic		)						(First, Middle	, Maiden Si	umame)	
Maryland	2 should be to and Mental I is marked of eumatic eve	2	Clyde E. Tho							ldie L				
lar	2 sh and is m	1 1	19a. Informant's Name/Rela		(Type, Print)			ng Address (Stre						ip Code)
	C = M F		Mark Jones/2	on		205		Andora	Vrive		とてON , M ate			Taura Chaha
ore	jes 1 a of Hea If item or othe		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremat	ion 3 [	Removal from	State	cemetery, cre	osition (Name of matory or other p	1				tion - City or T	
Ë	permit, Pages Department of h importent: If ite any injury or of	١.	*4 □Donation 5 □Oth	er (Speci	(y)	Ro		Cemeter					ing Su	
Baltimore,			21. Simplure of Funeral Ser	X	. So	odie	4	2. Name and Add					ral Ho	<sup>ng</sup> 1991 <sup>A</sup> .
760, 7	Wedical Examiner and project of principles o	al Examiner	23a. Parl1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease o. injury that initiated avents resulting in death) Last	e, or con List only	a. Due to	aused the delach line.  A ras a consi	equence of):	Infar			respiratory a	rrest,		Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			ointh 2 ☐ Fe nantattime o	ital death 3	⊒Ectopic pregnar ⊒ Other (s <i>pecify)</i>	псу			23	d. Date of deliv Month	very Day Year
	uires that n signed b	by	Part II. Other significant con	nditions	contributing to d	eath but not r	esulting in the u	inderlying cause (	given in Part	ł.	23e. Did 1			the cause of death?
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<u>ra</u>		ပိ	25. Was case referred to me	dical	1				26 Plac	e of Death	(Check only		1 103	2 140
5	s cert	To B	examiner? 1 XYes 2 No		Hospital:	Inpatient 2	☑ ER/Outpatie	nt 3 DOA	Othor				☐Other (Speci	ifv)
o	g Phys er this eral dii	Ë	27. Manner of Death			of Injury th, Day Year)			-	-	8d. Describe			
on	nding I tth. :: After e funer	tio		ending vestigation		in, Day rear)	Injury		ronk? ∐Yes 2.□	]No				
Division	i or Attending Physicien: after death. Director: After this certifica in by the funeral director, I	Certification:	3 ☐ Suicide 6 ☐ C	ould not etermine	4 288. Place	of Injury - At ing, etc. (Spe	home, farm, si cify)	reet, factory, offic	e	2	28f. Location ( City or To		Number or Rui	ral Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Cer (Check only one)	tifyIng P	miner: On the b	e best of my k easis of exami ner stated.	nowledge, dea nation and/or in	th occurred at the	time, date a y opinion, de	nd place, a ath occurre	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of ce	rtifier				29c. Lice	nse number			29d. Date	signed (Month	, Day, Year)
r	- > - O		> Tolle	m	1.3		mi	DO	0533	509		May	1a. a	004
	•		30. Name and address of on	on who	completed cau	se of death (II	em 23a) (Type	, Print)				4		
	2				Trongs	on M	<b>7</b> .	Union	Hosp	ital	ell	ktoi	1 MD	16916
	Sta Regist	ate rar	31. Date filed (Month: Day, MAY 1	(ear)	04	Registrar's Sig	nature	als			(	-		2192
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13, MAY **Physician** 12:05 PM 2004 RUSSELL LEONARD JOHNSON, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KNOLLWOOD MANOR NURSING HOME MILLERSVILLE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. FEBRUARY 17,1943 1**√**ΩM 2□F WASHINGTON, DC 217-42-1911 61 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Madical Exacutor coust be notified at 1 ☐ Yes 2 No Director PRINCE GEORGES LANDOVER MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2302 ROMNEY COURT 20785 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSEMAN FOOD SERVICE 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY GLADYS JOHNSON MACK LEROY ROBERT MACK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other traisonce. 2302 ROMNEY COURT, LANDOVER, MARYLAND MARTHA G. JOHNSON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. CHARLES CEMETERY MAY 20,2004 GLYMONT, MARYLAND 21. Senature of Funeral Securities and Licenses

LYDIA C. THORNTON JOHNSON MOO583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) WEE Physician PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, and additional cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď QUADRIPARESIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nhnown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After After Certification: 1 Viatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral D Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D31136

Registrar

State

BRIAN

31. Date filed (Month, Day, Xear)

9005 KICBRIDE RD, NOTTINGHAM, MID 21236

death (Item 23a) (Type, Print)

2004 Registrar's Signature

			1 - State of Maryland	/ Department of Health and Menta Certificate of Death	700	16981
	Physici	an	Decedent's Name (First, Middle, Last)	2. Da	Reg. No. te of Death onth Day Year	
***	/Medic Examir		4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospita  5. Sociat Security Number  6. Sex  7. Age (In yrs. last)	st birthday) If Under 1 Year tf Under 24 Hrs. 8 Days Months Days Hours Min. (Mo	4c. County of De  NONE te of Birth onth, Day, Year)  9. Bo	
	Director ** show ped in the ped i	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location  Tamp Springs	1y 4, 2004 M	aryland  10d. Inside City Limits  1XIYes 2 \( \text{No} \)
	be filed within 72 hours after death with the Maryland nta! Hygiene. od other than "naturel", or Iteme 23a or 28a-f show event, the Medical Examinat must be notified.	Funeral Director	10e. Street and Number  7210 Wessex Dr.  11. Marrital Status  12. Was Decedent Ever in U.S.	10f. Zip Code 20748  13. Was Decedent of Hispanic Origin? (Specify Ye	10g. Citizen of What C  U . S . A	1
9000	hours after d turel', or Iten al Exeminer	þ	Armed Forces?  1 ☐ Married 2 ☐ Married 1 ☐ Yes - 2 🛣 No  3 ☐ Widowed 4 ☐ Divorced	If Yes, specify Cuban, Mexican, Puerto Rican,  1 ☐ Yes 2♥ No Specify:	etc.) Black, Wh	ite, etc. Black
21215-0036	filed within 72 Hygiene. Other than "nat ent, the Medic:	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Infant	16b. Kind of Busines	s/Industry
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Baltimore, Man	t. Pages 1 and 2 sh trment of Health and rtant: If item 27 is m yjury or other traum		20a Method of Disposition 20b, Plac	19b. Mailing Address (Street and Number or Rural Route 210 Wessex Dr.Camp Spr 25 of Disposition (Name of Date	rings, Md 207	48
			1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	netery crematory of the place o	Clinton, Ma	ryland
B	Departiment in police.		MO1323  23a. Part 1. Enter the disease, or complications that caused the death.			Approximate
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68760,	cate be executed physicien and into burial-transit	dical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence)  c. Due to (or as a consequence)			10 weeks
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Division	tel or Attenors after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office 28f. Loc. City	ation (Street and Number or Ri r or Town, State)	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	one) 2   Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, and due n and/or investigation, in my opinion, death occurred at the	to the cause(s) and manner as time, date and place, and due	s stated. e to the cause(s)
7	To with To corr	2	29b. Signature and title of certifier	29c. License number RES -000	29d. Date signed (Mont	th, Day, Year) ZDOY
n	) P () Sta	te.	30. Name and address of erson who completed cause of death (Item 2:	North Wolfe Street	Baltimore	MD 21257
	Registr		MAY 1 7 2004	15 Apolles		

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¥.	Funeral Director		5. Social Security Number 6. S 213-22-8253 2	ex 7. Ag	e (In yrs. last	r birthday) If Un Yrs. Month	der 1 Year	If Under 24 Hrs Hours Min.		th ay, Year) /191	Coun	lace (State or Foreign try) ngton D.C.
	υ .		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Location						Od. Inside City Limits
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Exactinal for notified at ance.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, GiveX Year or Dates:	No		s 2 No	an, Mexican, Puèr Specify:	to Rican, etc.)		Specify: White	
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	Mental Hygie Mental Hygie arked other attc event, II	Be	17. Father's Name (First, Middle, Last) Harry Frances Ki	cams		51	:		me <i>(First, Middl</i> e nia Hunte		Sumame)	
Maryland	should ind Men in marke	ဥ	19a. Informant's Name/Relationship (			19b. Mailing Addr	ess (Street				r Town, State, Zip	Code)
	1 and 2 Health a tem 27 is		Penny George / Da	aughter				Road, S	Sudlersvi		Marylan	
nore	Pages 1 nent of H int: If Itel		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐		cem	e of Disposition ( etery, crematory on peake. Cr	or other plac				cation - City or To	sville, MD
Baltimore,	permit. Pages 1 al Department of Hea Important: If Item any injury or otha once.		*4 □ Donation ★□ Other (Specification 21. Signature of Funeral Service Licer		1	22. Name	and Addre	ss of Facility				
100	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plic door that caused one cause on each life.  a. Due to (or as b.	ic S	Hock	V. CYP	ress STr ng, such as cardia	reet, Mil	lling	ton, Mar	Vland 2165 Approximate Interval Between Onset and Death
68760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to a minutial cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last	c. Due to (or as								
.O. Box	ut the death certificate to by the attending physicached for use as the tached for use as the teched for use a	Physiclan/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3 Ectopi	ic pregnancy (specify)			2	23d. Date of delive Month	ory Day Year
٥.	es tha gned be de	d by	Part II. Other significant conditions of	contributing to death b	ut not resulting	ng in the underlyin	ng cause giv	ren in Part I.		tobacco u Yes 2[		ne cause of death? ably 4 Unknown
of Vital Records,	The ate ha	Complete							24a. Was auto perfe 1 Tyes		24b. Were autoprior to condeath?	psy findings available mpletion of cause of
Vita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			DOA OU	ARI.	ath (Check only			
	Phys	n: To	1 Yes 2 No 27. May of Death	28a. Date of Inju	iry 28	Bb. Time of	28c. Injur	4 🔲 Nursing i	Home 5 Res		S Other (Specif) y occurred	′)
Division	eat tor:	Certification;	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In		Injury M e, farm, street, fac	1 🗆	Yes 2 □ No	28f. Location ( City or To		d Number or Rura	I Route Number,
ا	To the Hospital or Att within 24 hours after of To the Funaral Direct completely filled in by			ysician: To the best		edge, death occur	red at the til	me, date and plac				rated.
	the Hoshin 24 h the Fur	edicai	(Check only 2 Medical Examone)	niner: On the basis of		n and/or investiga			urred at the time,			
)	with To I	Σ	29b. Signature and title of ertifier	4		-	29c. Licens	00603	0)	29d. Dat	e signed (Month, )	Pey, Year)
			30. Name and address of person who				d 59	rs c	+ ESPENC	Tow	w, w	D 21620
	St Regist	ate rar	31. Date filed (Month, Pay, Year) APR 3 0	2004 32. Refistr	ar's Signatur	to do	All s					

		1 - State RegistrarAMFND TIFM #2 1. Decedent's Name (First, Middle, La	4a PER VERB (	£31 5/27/ <b>0</b> 4	эднисан	e oi Dea	zu i	2. Date of Dea			3. Time of Death
Phýsici /Medio		Richard Edwar	d King,	Sr.				Month April	Day 13	2004	5:20 P
Examin		4a. Facility Name (If not institution, gi	re street and number)		4b. City,	Town, or Loca	ition of Death		4c.	County of Deat	th
		990 Waterford D			+	Frederi	ck nder 24 Hrs.	0.0	F	rederic	
uneral irector			Sex 7. Ag 1⊠XM 2□F	e (In yrs. last birthda) 80 Yrs.	Months		urs Min.	8. Date of Birt (Month, Da) July 27	Year) 19	23 Vir	hplace (State or Forei buntry) ginia
<b>&gt;</b> 10000		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limit
show	ō		o.le	Freder							1⊠Yes 2 □ N
28a-1	Director	Maryland Frederi  10e. Street and Number	CK	rreder	10f. Zip	Code			10g. Citi	zen of What Co	ountry?
3a or	0	990 Waterford Dr	ive			21702	)		Un	ited St	ates
T B	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	B. Was Deced	dent of Hispani of Cuban, Me	ic Origin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
od other than "natural", or itams 23a or 28a-f shov event, the Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	No WWII Korea	,	2⊠No Sp					White
netur lical	Completed	15. Decedent's E (Specify only highest g	ducation ade completed)	16a. Dec	edent's Usua ve kind of wo	al Occupation ork done during se retired)	most of work	ing	16b. Ki	nd of Business/	Industry
than "	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	. <i>DO NOT u</i> s ner/Ope				^n+	iano Ch	ıon.
marked other than		17. Father's Name (First, Middle, Las	3	OWI	ie i / Ope		Mother's Nam	e (First, Middle,		ique Sh	юр
arked o	To Be	Omer P. King, Sr				. 1	Jinnifr	ed Keel	e v		
is mari eumati	F	19a. Informant's Name/Relationship		19b. Ma	iling Address			al Route Numbe		r Town, State, 2	Zip Code)
27 is		Mary K. Peterson	/ Daughte	r 8515	Roseb	ud Cou	rt M	iddletow	m, N	larylano	d 21769
ff item 27 is marke or other treumatic		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	Dameual from State	20b. Place of Dis	position <sub>4</sub> (Nar rematory or o	me of other place)		Date 1 15	20c. Lo	cation - City or	Town, State
ant: fi		'4 □ Donation 5 □ Other (Spec		Frederic				1 15, 2004, I	red	erick, l	Maryland
Importent: If any injury or pnce.		21. Signature of Eurocal Service Lice	ensee			nd Address of I	שני				nes, P.A. yland 2170
/sician ledical aminer		23a. Part1. Enter the disease, or cor shock, or heart failure. List onf Immediate Cause (Final disease or condition resulting in death)	a Me	tastatic		on C			rest,		Approximate Interval Between Onset and Death
\$0.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence of):							
been signed by the attending physician and should be detached for use as the burial-transit	cal	resulting in death) Last	Due to (or as	a consequence of):							
iding ph	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date of del	livery
the atter ched for u	ystclar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		B⊟Ectopic pr □ Other (sp					Month	Day Year
signed b	Completed by Physician/Med	Part II. Other significant conditions    Schemic.	contributing to death t	L	underlying o	cause given in	Part I.		bacco u es 21		the cause of death?
SO	nplete			7 /	/			24a. Was autop		24b. Were au prior to death?	utopsy findings availa completion of cause
pa								1 Yes	2 <b>XX</b> No		2 No
certif	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ent 2 ER/Outpat	ient 3□ DC	Other	Tarii.	h <i>(Check only o</i> ome 5 <b>X</b> Resid	I a line	E DOthar (Cas	nife)
il. After this certific funeral director,	H-1	27. Manner of Death	28a. Date of Ini	urv 28b. Time		28c. Injury at Work?		28d. Describe h			City)
ctor; Afte	atlor	1 Natural 5 Pending 2 Accident investigati	(Month, Da	ay Year) Injury	м	Work? 1 ☐ Yes	2 🗆 No				
To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	200. Flace of its	jury - At home, farm, tc. (Specify)	street, factor	y, office		28f. Location (S City or Tox			ural Route Number,
uneral	edical C		Physician: To the best miner: On the basis of and manner s	of examination and/or							
et e	9	29b. Signature and title of certifier			290	c. License nun	nber		29d. Dat	e signed (Mont	h, Day, Year)
Fo the Formplete	Σ					-			1	10	2.11
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	2	30. Name and a x rais of person wh	- MD			D005	7362	own,	UP)	sil 14	, 2004

			1 = For State Registrar AMEND TIEM	State of #26 PER PHY (	Marylan 3831 5/2	d / Depa 7/04 <i>Ce</i>	artment tificate	of He	ealth an <i>eath</i>		A	eg. No.	004	16986
п	Physici	an .	Decedent's Name (First, Middle		Klin	0					Date of Dea Month 1ay 17,		Year	3. Time of Death 5:35 P. M
3	/Medic Examin		David  4a. Facility Name (If not institution  800 Motter			ie .	4b. City, T		ocation of D	Death	lay 17,		nty of Death Fred	
	Funeral Director		5. Social Security Number 213-40-4967	6. Sex 7. 1 <b>X</b> JM 2□F	Age (In yrs. 61	last birthday) Yrs.	If Under 1 Months	Year Days	Hours 1	Min.	Date of Birth (Month, Day )ec. 26	Year)	9. Birth Cou	place (State or Foreign aryland
	Maryland a-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland F	rederick	10c. City	y, Town or La		Fred	erick					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Dire	10e. Street and Number 800 Motter Ave	mue			10f. Zip (	Code	21701		1	0g. Citizen d	of What Cou .S.A.	ntry?
36	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "naturel", or Itams 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married  Marital Status  3 Widowed 4 Divorced	12. Was Deceded Armed Forcined 1 Tyes 2	es? ∑į No		Was Decede f Yes, speci				fy Yes or No- can, etc.)	14. R	ace - Ameri lack, White,	
21215-0036	within 72 hour ene. than "nature the Medical E	Completed I	15. Deceden	t's Education st grade completed)		(Give	dent's Usual kind of work DO NOT use YUCTI	done du retired)	ring most of	f working		16b. Kind of		ontracting
	e filed within al Hygiene. other than vent, the we	Be Co	17. Father's Name (First, Middle,	Last)		COLIS	Lucti			Name (F	First, Middle, I			MICLACCING
ylar	ould be Menta	ToB	Roy Keefer KJ								e Edna			
, Maryland	s 1 and 2 should Health and Men Itam 27 ie marke other traumatic		19a. Informant's Name/Relations Betty Moser/S			1601	Jenni	ngs (		Fre	Route Number ederick	, Mary	land	21702
Baltimore,	00-		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S	(pecify)	ate Smi	Place of Dispo emetery, crer ENSOUT	g Crei	ner place) ma to:			, 2004		ithsbu	own, State Irg, MD
Balt	permit. Pag Department Important: I eny injury o		21. Signate glot Funeral Service	C. May			106 E	ast 1	Church	Str	Funera	rederi		D 21701 Approximate
8760,	Physician / Medical Examiner   Medical Examiner   Physician and   Physician an	licai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consequence of the conseq						eroi	1		Interval Between Onset and Death
Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal	Ideath 3□	Ectopic pre						Date of delived	ery Day Year
rds, P.O.	The law requires that the ste has reen signed by the bage 2, should be detache	ρχ	Part II. Other significant conditi	ons contributing to dea	th but not res	ulting in the u	nderlying ca	usa giver	n in Part I.		23e. Did tol		ntribute to t	he cause of death? pably 4 Unknown
I Records,		Completed							<u>.</u>	_	24a. Was a autops perform	y	prior to co death? 1 Yes	opsy findings available impletion of cause of
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medica examiner? 1 ☐ Yes 254 No	Hospital:		ER/Outpatier	, all po	Other			Check only on		Ab /C	
Division of	ing After une	Certification: To	27. Manner of Death  1 Natural 5 Pendir  2 Accident investi  3 Suicide 6 Could	gation	Injury Day Year)	28b. Time of Injury	M 28	Nork?		280	d. Describe ho		urred	
Divi	oital or Attandurs after deathurs after deathurs! Diractor: ,	Certif	4 Homicide determ	building	f Injury - At ho g, etc. <i>(Specif</i> )	y)					City or Town	n, State)		al Route Number,
	To the Hospital or within 24 hours after To the Funerel Director completely filled in b	Medicai	(Check only one)	Examiner: On the bas and manne	is of examina	wledge, death	vestigation,	în my opi	nion, death o	occurred	at the time, d	ate and place	e, and due t	o the cause(s)
•	with To		29b. Signature and title of serving	ovrier	2,1	MI	) 290.	DO C	95	12		9d. Date sign	18-	-01
	6		30. Name and address of person  Jean R. Poir	who completed cause				n_Dr	ive. 1	Fred	erick,	Mary1	and 2	1702
	Sta Regist		31. Date filed (Month, Day, Year, MAY 2 7 200)	32. Reg	gistrar's Signa	iture	oak					- <del> </del>		

		For Amend Item #20h8238 per Invaria 6831 5/27	Atment of Health and Mertificate of Death	lental Hygi	g. No. 4 UUL	1698
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)     Betty K. Littlepage     4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month May	Day Year  6 2004  4c. County of Deat	3. Time of Death 12:40P M
Funeral Director	-	7753 Outing Avenue  5. Sociel Security Number 214 12 4890  6. Sex 1 M 2 Sept 7. Age (In yrs. last birthda) Yrs.	Pasadena  // If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, 5-8-192	Anne An Year) 9. Birtt Co 21 Man	cundel  place (State or Foreign  ryland
d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene 77 is marked other than "naturel", or items 23e or 28e-f show traumatic event, the Macified Exerciter count be notified at	Be Completed by Funeral Director	1 Never Married 2 Married 1XIVes 2 No If Yes, Give Year or Dates: 1942-46  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		ecify Yes or No-Rican, etc.)	6b. Kind of Business/I	States ican Indian. o, etc.  White industry
permit. Pages 1 and 2 should be Department of Health and Mental Department of Health and Mental Moortant: If item 27 is marked to any injury or other traumatic events.	Tof	Sarah Littlepage/Daughter 1317  20a. Method of Disposition  1  principal 2 Cremation 3 Removal from State  1  Donation 5 Other (Specify)  20b. Place of Disposition Cemetery, critical Companion State  Loudon	Carrie ling Address (Street and Number or Rura W. Baltimore Street and Number or Rura Would be a street and Number or Rura W. Baltimore Street and Number or Rura Street and Number of Pace Park Cem. 5/11/ 22. Name and Address of Facility Har	Al Route Number, at . Balt Date 20	cimore, M Oc. Location - City or T Baltimore	ID 21223  Town, State  2, MD
eath certificate be attending physicie for use as the bu	Physician/Medical Examiner	1 Yes 2 King 4 Pregnant at time of death 5	Alzheimer's Disea	, ,	23d. Date of deline	Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death Death Death Death Death Death Death Death Death Death Death Death Death Death Death D
Hospital or Attending Physicien: The law requires that the L24 hours after decreases. The law requires that the Funeral Directors. After this certificate has been signed by the Mely filled in by the funeral director, page 2 should be detached.	ledical Certification: To Be Completed by Physi	Part II. Other significant conditions contributing to death but not resulting in the  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Noshital: 28a. Date of Injury (Month, Day Year) 1 Noshital: 3 Suicide of Could not be determined 28b. Time (Month, Day Year) 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29 Wedical Examiner: On the basis of examination and/or is and manner stated.	26. Place of Death  26. Place of Death  ant 3 DOA Other: 4 Nursing Hor  of 28c. Injury at Work?  M 1 Yes 2 No  treet, factory, office	24a. Was an autopsy perform 1 Yes 2 of (Check only one).  The second of the second of	24b. Were authorized to clearly 1 Yes  Compared to Compare to Comp	bably 4 Unknown  opsy findings available ompletion of cause of  21 No  fy)asst 1vo  al Route Number,
Sta Registre	≥	30. Name and address of person who completed days of death (Ite/n 23a) (Type 31. Date filed (Month, Day, Year)  MAY 1 0 2001	Malisa Park	- Oreve,	d. Date signed (Month) 05/07/09 602 9014	Day, Year)

		·	1 - For State Registrar	State of M	larylan	d / Depa <i>Cei</i>	artment of	f Health of Death	and Me	ntal Hygi	ene 20	104	16	988
			1. Decedent's Name (First, Middle,	Last)			-		2.	Date of Death	Day	Year	3. Time of	Death
	Physici: /Medic		Betty	Lou	Lam	bk <b>a</b>			I	May 6,	2004		2:15	A . M
Ì	Examin		4a. Facility Name (If not institution,					n, or Location			4c. County	of Death		
			Garrett Count						kland	. Date of Birth	Garı		lana (Dana)	. Form law
	Funeral Director		5. Social Security Number 166541766  Usual Residence of Decedent	5. Sex 7. A 1 ☐ M 2 🖾 F	70	last birthday) Yrs.	Months Da		Min.	(Month, Day,	<sup>Year)</sup> 1934	West	lace (State or etry) Virgi	inia
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside Cit	y Limits
	Many 14 sh	į	WV Pre	eston			Co	rinth					1 🗌 Yes	2 🔯 No
	or 28g	Director	10e. Street and Number				10f. Zip Cod			10	g. Citizen of V	Vhat Cour	itry?	
	th wil	ai	RR 1 Box 424					267				USA		
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Modical Exaculturer, ust be rutillised at once.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	If Yes, Give	:? ] No	1	Was Decedent of Yes, specify C			y Yes or No- an, etc.)		k, White,	an Indian, etc. hite	
Ö	hour: tural	De De	3 ☑ Widowed 4 ☐ Divorced	Year or Dates		16a Dece	dent's Usual Oc	cupation		1	6b. Kind of Bu	siness/Inc	fustry	
Ϋ́	in 72	Completed	(Specify only highest	grade completed)	.5.	(Give	kind of work do DO NOT use rei	ne during mos	st of working	'	00. 14110 01 00	10111000	200119	
72	iene.	E O	Elementary/Secondary (0-12) 12th	College (1-4o	r 5+)		House	ewife				Home	2	
פַ	be filed value by the land of the land other	ВеС	17. Father's Name (First, Middle, La	ist)		<u> </u>		18. Moth	er's Name (F	First, Middle, M	aiden Sumam	Θ)		
<u>lar</u>	should by and Menta marked umatic e	ToE	Eston Dan	ъу	Cosne	r		N	ellie	1	Mae	Sh	reeve	
Maryland 21215-0036	2 sho and h		19a. Informant's Name/Relationshi				ng Address (Stre					State, Zip	Code)	
	and sealth m 27		Daniel E. Lambl	ta/son	00h F	-	1 Box 4		rinth,			O'1 T-		
ore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Stat	1 0	emetery, crer	osition (Name of matory or other p	place)	Date	9 2	0c. Location -	City or 10	wn, State	
<u>=</u>	tmen tant:		`4 □Donation 5 □ Other (Spe				d Cemet			004 <u>F</u>				
Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Bervice L	Literal		3	2. Name and Ad 2. S. Se	cond S	t., 0a		Md. 21			
	Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that cause nly one cause on each  a. Acute  Due to (or a	Rena	l Fai	_	dying, such as	cardiac or re	espiratory arres	st,	4	Approximate Interval Betwood Onset and D	veen Death
	Examiner			Sepsis	is a conseq	derice or).						5	Days	3
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury	b. Due to (or a	s a conseq	uence of):					<del></del>			
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Acute A	Pyelo	onephi	citis					5	Days	3
760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a	s a conseq	uence of):								
928	ate br hysic the br	licai	•	d										
P.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3	Ectopic pregna Other (specify,				23d. Date Mor	e of delive	-	'ear
	s that t ned by e deta	y Ph	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause	given in Part I	1.	23e. Did toba	acco use contr	ibute to th	a cause of de	∍ath?
ords	w requires to been signer should be	ted b	Type 2 Diabet	es		Diabe	tic Ne	phrop	athy	1 □ Yes	2X No	3 Prob	abiy 4 □Ui	nknown
Reco	he law ru e has be ige 2 shi	Completed	Osteomyelitis							24a. Was an autopsy perform	ed? d	eath?	osy findings a npletion of ca	vailable iuse of
ta	an: T tifficati or, pe	e C	Coronary Arte 25. Was case referred to medical	Ly Diseas	. e			26. Place	e of Death (C	1 ☐ Yes 22 Check only one		□Yes	2A I NO	
<u> </u>	ysici is cer direct	0 8	examiner? 1 ☐ Yes 2∑ No	Hospital: 1 X Inpat	tient 2	ER/Outpatien	nt 3 DOA			5 🗌 Residen		or (Specify	')	
Division of Vital Records,	Jing After	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28b. Time of Injury	28c. lr	njuryat Work? □Yes 2□	280	f. Describe how				
Divis	a Hospital or Attens 24 hours after death Funeral Director: etely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 286. Place of I	njury - At ho etc. <i>(Specif</i> )	ome, farm, str y)	eet, factory, office	се	28f	. Location (Stre City or Town,		er or Rura	l Route Numb	er,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical (	29a. Certifier 1⊠ Certifying (Check only one) 1 Medical E.	Physician: To the bes xaminer: On the basis and manner s	of my kno of examina stated.	wledge, death tion and/or in	h occurred at the vestigation, in m	e time, date ar ny opinion, dea	nd place, and ath occurred	due to the cau at the time, dat	ise(s) and mar e and place, a	nner as st and due to	ated. the cause(s)	
	To th withir To th compi	Me	29b. Signature and title of certifier	7			29c. Lice	ense number		29	d. Date signed	(Month,	Day, Year)	
ř			1/ John Co	gh mo			DO	033464	4	Ma	у 6,	2004	Į	
	3		30. Name and address of person w	no completed cause of	death (Iten	п 23а) (Туре,	Print)			l				
_			Robert M. Cou				ox 8,	Eglon	, WV	26716				
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1		trar's Signa		mode							

		1 - State Registrar AMEND TIEM #10		G831 5/	27/04C <b>a</b> ti	tificat	e of L	Death		2. Date of De	Reg. No.	200	3. Time of Death
Physici	an	Joanne Louise	Landen	horao	r					Month May 10	Day	Ye	er
/Medic		4a. Facility Name (If not institution, give			<u> </u>	4b. City,	Town, or	Location of [	Death	may 10		County of E	4:13PM
Examir	ier	227 Carroll Stree		,			mber:					11ega	
Funeral Director		5. Social Security Number 6. Se 216-52-3768	x 7.	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, Da Oct. 1	th	9.	Birthplace (State or Fore Country) aryland
		Usual Residence of Decedent											
fied at	tor	MD 10b. County Allegan	Y		ty, Town or Lo nberlan								10d. Inside City Lim XXYes 2 □
Sa or 28s	i Direc	10e2Street and Number 237 Court Carrol	Street			10f. Zip	Code 2150	2			10g. Citiz	en of What	t Country?
Department of Health and Mental Hyglene. Important: if items 23a or 28a-f ehow Important: if item 27 is marked other than "naturel", or items 23a or 28a-f ehow appringut or other traumatic event, if a Mudical Examination traulitied at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	as? <b>⊠</b> No	1	Vas Deced f Yes, sped I ☐ Yes			n? (Spe Puerto F	cify Yes or No Rican, etc.)			American Indian, White, etc. White
n nature Mudical E	Completed b	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced (Give life. I	lent's Usu: kind of wo DO NOT u	rk done d	uring most of	f workin	ng	16b. Kir	d of Busine	ess/Industry
giene er the	E O	11 yrs	Oonogo (1 4	01 317	homen	aker					(	own ho	ome
fental Hy rked othe tic event	To Be C	17. Father's Name (First, Middle, Last) Lloyd Kenneth Be	aulac							(First, Middle, Ervin	Maiden 3	Sumame)	
ulth and N 27 le mai r traumai		19a. Informant's Name/Relationship (T) Charles Landenbe:		band						Route Number			
of Health ar	H	20a. Method of Disposition  1 \( \mathbb{D}\) Burial 2 \( \mathbb{C}\) Cremation 3 \( \mathbb{D}\) F	lomoval from Sta	1 /	Place of Dispo	sition (Nar	ne of other place	)	Di	ate	20c. Loc	ation - City	or Town, State
ant: It		'4 □Donation 5 □ Other (Specify)	A	Pa	rkwood	Cemet	tery	5/	/13/	<b>′</b> 04	Ba1	timor	ce, MD
Departi Importi eny inj		21. Signal e of Funeral Service Licens	Clear	Der	22 M H	Name and larkwo	od Address DOG F BOX S	of Facility uneral 12, Ke	L Ho	ome, In	c. 26726	5	
ysician and Medical aminer the printing the	cal Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or		puence of):	nary	dise	ase					Interval Between Onset and Death  Years
ed by the attending physic detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	d	n 2∏Feta tattime of d	Il death 3	Ectopic pr					23	3d. Date of Month	delivery Day Year
P 9	þ	Part II. Other significant conditions con	ntributing to deat	h but not res	ulting in the ur	iderlying c	ause give	n in Part I.		23e. Did to	_		e to the cause of death? Probably 4 Unkno
is certificate has been si director, page 2 should	Completed								<del></del>		an sy med? 2. No	24b. Were prior death	
certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:				Othe			(Check only o	ne)		
a ≑	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of I		28b. Time of Injury	2	Bc. Injury Work	at	-	8d. Describe h			(pecify)
er deat ector: by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury - At he etc. (Specif	ome, farm, stre	M eet, factory		es 2 □ No	2	8f. Location (S City or Tow		Number or	Rural Route Number,
within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifying Physical Certifying Physical Exeminates	sician: To the be ner: On the basis and manner	s of examina	wledge, death	occurred estigation,	at the time , in my opi	, date and p nion, death o	lace, ar	nd due to the o	ause(s) a date and p	nd manner blace, and c	as stated. due to the cause(s)
within To the comple	Me	29b. Signature and little of certifier				290	. License	number		- :	29d. Date	signed (Mo	onth, Day, Year)
- P 0		> (Xeu)	Tra			Ī	D09	157		1	May 1	1 200	)4
	1	30. Name and address of person who co	lated	6 dant /14-	n 00a) (T 1	Delet)							

			State of Maryland / Dep State Registrar AMENI) TIEM #12825 PER FH & Phy g831 Ce	artment of Health and Me crificate of Death	ental Hygien Reg. N	100 00 00 1	6990
I	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Ti	ime of Death
7	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	april ,	13 2004 5	10-5-0 PM
	Examin	er	LEVINIALE	BALTIMERE	-		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 13-24-8016 1 M 2004 7 Yrs.	Months   Days   Hours   Min.	8. Date of Birth (Month, Oay, Yea	9. Birthplace (S Country) 925 Hopehi	.1 2 4
	yland now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L				ide City Limits
	8a-fsh	Director	NO FREDERICK FREDE				Pres 2 □ No
	th with the 23s or 2	ai Dire	3819 Big Woods Rs.	21754		Citizen of What Country?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If itam 27 Ia marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent. The Medical Examinations invitied at 000s.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes XX No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - American Indi Black, White, etc.	an,
21215-0036	within 72 ho ane. than "natur in Medical I	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) ONEMAKER		Kind of Business/Industry	
Maryland 2	uld be filed Menta! Hygii irked othar itlc avent, II	To Be Co	17. Father's Name (First, Middle, Lest)  JOSEPH R. LEE	18. Mother's Name	(First, Middle, Maide		
	and 2 should ealth and Men n 27 la marke ter traumatic	d	19a. Informant's Name/Relationship (Type, Print) Aughter) 19b. Mail 381	ling Address (Street and Number or Rural 9 B19 Wools Re		y or Town, State, Zip Code) SVIII & M.J.	-11
Baltimore,	Pages 1 a nent of Hea int: If itam iry or othe		1 Ponation 5 Other (Specify)	ematory or other place)  (h: 2 6 (Em 4-19)	-ast IT	Location - City or Town, Sta	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility GAR 10 West South St A	y L Roll	MY 21701	ONE
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or flear failure. List only one cause on each line.  Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac or	respiratory arrest,	Interv	oximate al Between t and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury				
8760,	cate be executed physician and the burial-transit	dicai Exar	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d				
P.O. Box 68	ne death certific the attending p hed for use as	Completed by Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
	iw requires that the sound is been signed by should be detact	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the caus	
Vital Records,	The taw rec te has bee age 2 shor	ompiete	CVA Dispheria		24a. Was an autopsy performed?		n of cause of
/ital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
ō	y Physi er this c eral dire	n; To	1 Yes XXNo   Tospital: 1 Inpatient 2   ER/Outpatie 27. Manner of Death   28a. Date of Injury   28b. Time	of 28c. Injury at 2	e 5 Residence	6 ☐ Other (Specify)	
sion	ttanding I death. ctor: After y the funer	atio	2 Accident investigation	M 1 Tyes 2 No			
Division	after de Diract	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office	8f. Location (Street and City or Town, Sta	and Number or Rural Route ate)	Number,
	To the Hospital or Attanding Physician: The within 24 hours after death.  To the Funaral Diractor: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or i and manner stated.	ith occurred at the time, date and place, an investigation, in my opinion, death occurre	nd due to the caused d at the time, date a	(s) and manner as stated. ind place, and due to the ca	iuse(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Ye	
			30. Name and ad ress of person who completed cause of death (Item 23a) (Type	05-65-08	SHAL	ril 14, 20	204
	+		2734 W Belvedere ave, 15	3 altimore, MD	21215		
ı	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature  APR 2 0 2004	& Spark			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gary McGregor State of Maryland / Department of Health and Mental Hygiene 04-3413 1 - State Registrar Certificate of Death Reg. No. 2 AKG 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** McGregor Gary 2004 May 21, 5:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 7013 Kent Town Drive Landover If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**☆**M 2□F Months Days Hours Min Yrs. 54 Director 110-38-7087 NY Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director VA Loudoun Leesburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 120-2 Washington Street 20176 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) be filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Appliance Technician 6 Maytag 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Elizabeth M. Kramer Vernon A. McGregor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 195 Martin Road Edna M. McGregor - Wife Narles, NY 14512 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Adams-Green Funeral 05/24/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Herndon, VA 22. Name and Address of Facility 21. Signature of Funeral Service License Adams-Green Fu 721 Elden St., Funeral Home Herndon, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician MShot wounds Que to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine nding physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant the atten 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) o detached 9 Unknown ģ as been signed of 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Ses 2 No 24a. Was an has page 1 Yes certificate 2 No Vital Physicien: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6X Other (Specify) At SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X Yes 2 □ No this funeral 28a. Date of Injury at Unjury at Unjury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending 0516 1 ☐ Yes 2 XNo investigation death 2 Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Jown, Stries filled in by 4 Momicide Stor Driv Hospitel or 10 Car 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 21, 2004 all wo 0 Lon Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

STRICIA

31. Date filed (Month, Day, Year) MAY 2 7 2004 MD111 Penn Street, Baltimore, Maryland 21201

SILA

Could

32. Registrar's Signature

TONICA

		ı	For	State of Maryland	d / Depa		ealth an	•	iene	2.0.	
			1 - State Registrar		Cei	rtificate of L	Death		g. No. 2	104 169	97
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deal Month	Day	Year 3. Time of Dea	Ath
۵ ـ	/Medic		Robert Francis  4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of D	May	4c. County	004 1:30	P
	Examir	er	Calvert Manor Hea		п	Rising			Cec		
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 !	Hrs. 8. Date of Birth		Birthplace (State or Fo Country)	reign
	Director		200 32-0378	M 2□F 61	Yrs.	Months Days	1,00,0	June 16	, 1942	PA	
and	* =		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Li	imits
Mary	-f eho	ţō	MD Cecil	RA	ising	Sun				1 ☐ Yes 2 🕅	No
h the	or 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Country?	
:1215-0036 within 72 hours after death with the Maryland	nd Mental Hygiene. marked other than "natural", or flems 23a or 28a-1 show matte event, the Medical Examiner must be notified at	Funeral Director	1881 Telegraph Ro	ad		21911			USA		
er des	items per m	nue	Tr. Wanter States	12. Was Decedent Ever in U.S Armed Forces?	5. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? In, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)		e - American Indian, k, White, etc.	
36 Is aft	var.	by F	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify	" White	
Maryland 21215-0036 id 2 should be filed within 72 hours af	etura ical E	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ation	un et in e	16b. Kind of Bu	usiness/Industry	
212 Thin 7	Med "	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	Working			
21 Pg W	lygien her th it, the		12		Pol	ice Chief		Name (First, Middle, I		Gov't	
and be fi	ntal Hygie ed other t event, In	Be	17. Father's Name (First, Middle, Last)  Robert McCaw					er Whalen	naiden Suntani	(6)	
should	mark mark	2	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Street a		r Rural Route Number	City or Town,	State, Zip Code)	_
	f Health and Meniton 27 is marke		Jeffrey McCaw/So	n	16	Bromell L	ane, R	ising Sun,	MD 219	11	
ore,	of Hear		20a. Method of Disposition  1 Burial 2 Cremation 3 R	20b. Pl	ace of Dispo	sition (Name of matory or other place	e) 05	-12-2004	20c. Location -	City or Town, State	
Pages	ment: hant: h		'4 □Donation 5 □ Other (Specify)	R.T.		d Funeral	Home,	P.A.		g Sun, MD	
Baltimore,	Department of Heal important: If item 2 eny injury or other once.		21. Signature of Engeral Service License	ni W	- 22	2. Name and Addres	en Str	R.T. Foard eet, Risin	Funera g Sun,	L Home, P.A. MD 21911	
	#		23a. Part1. Inter the disease, or complishock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not ent	er the mode of dying	g, such as car	diac or respiratory arre	est,	Approximate Interval Between	n
	nysician		Immediate Cause (Final disease or condition	410501	1515					Onset and Deat	
200	Medical xaminer		resulting in death)	Due to (or as a consequ	ience of):						
		- G	Sequentially list conditions,	Due to or as a consequ	ience of:						
10 3	ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
760, 7/	nysician and he burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):						
	hysici the bu	Ilcai		d							
I Records, P.O. Box 68 The law requires that the death certificat	been signed by the attending phy should be detached for use as th	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnar	201						
Vital Records, P.O. Box sician: The law requires that the death cer	attend for us	ian	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery hth Day Year	
o ş	y the	ysic	1 Yes 2 No 9 Unknown	9 Unknown		Cition (Speciny)					
s that	ned b e deta	y P	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to the cause of death	1?
ords	en sig ould b	ted k	BPH	4				1 Y€	s 2000	3 Probably 4 Unkn	IOWN
ecc law r	S CI	ple	atrial Fibrillat					24a. Was a autops	y p	Vere autopsy findings available to completion of cause	lable a of
<b>E</b>	page,	Con	cerebrovasculo	er accident				perform 1 Tes	ned? d	leath?  Yes 2 No	
Vita lician	certificate has b	Be	25. Was case referred to medical examiner?	Hospital:		Othe	0.0	Death (Check only on	-		-
P Ş	or this aral di	To :	1 Yes 2 No	28a. Date of Injury	28b. Time of	f 28c. Injury	at	ng Home 5 Reside			_
Division of	uth. r: Afte e func	atlor	Natural 5 Pending investigation	(Month, Day Year)	Injury	Work M 1□'	<br Yes 2□No				
Vis	after death   Director: , d in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (St. City or Town		er or Rural Route Number,	
ital D	rs aft ral Di lled in										
Division of Vital	within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier Certifying Physical Check only 2 Madical Examination	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the tim vestigation, in my op	ne, date and pl pinion, death o	lace, and due to the ca occurred at the time, da	iuse(s) and mai ate and place, a	nner as stated. and due to the cause(s)	
To the	vithin Fo the	Me	29b. Signature and title of certifie	00 00		29c. License			9d. Date signed	i (Month, Day, Year)	
	71-0		1 Develal Ol	( )		0000	20346	.0	5/12/	04	
	-)		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type.			lherdee/			
	_		Prashant Shuk (s 31. Date filed (Month, Day, Year)	32. Registrar's Signat		arke) Tr	rett	inerdee!	راحی	2100)	
	Sta Regist		MAY 1 4 200	61		reals)					

		For State Registrer		of Man	yland / Dep <i>Ce</i>	artmen rtificate			and N	Re	g. No.2	04	15993
Physicia	n	Decedent's Name (First, Midd  Jeanne	e, Last) Mar	ed o		MADEC	DAE			2. Date of Death	Day	Year	3. Tilme of Death
/Medica		4a. Facility Name (If not institution				MARKG 4b. City.		Location	of Death	April	19 , 20 4c. County	004 of Death	6:08 P M
Examine	1	Cuppett Weeks				,		0akla					rett
Funeral		5. Social Security Number	6. Sex	7. Age (I	In yrs. last birthday	If Under Months		If Under Hours		8. Date of Birth (Month, Day,	Year)	,	place (State or Foreign intry)
Director		175-182559 Usual Residence of Decedent	1□M 2K31		83 Yrs.		Days	nours	IVIII I.	Oct. 17,	1920	Pe	nnsylvania
e-f show	ctor	MD 10b. County	arrett	10	Oc. City, Town or L		1and						10d. Inside City Limits 1 StYes 2 □ No
or 28	Olre	10e. Street and Number				10f. Zip	Code			10	g. Citizen of		
ath w	ē	806 Heritage I						215		7 7 7	14 50	USA	
urs a	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mai  3 ☑ Widowed 4 ☐ Divorced	ried 1 TY	Decedent Event Forces? es 2 X No Give or Dates:	ar in U.S. 13.	Was Deced If Yes, spec			gin? (Sp 1, Puerto	ecify Yes or No- Rican, etc.)		ck, White,	can Indian, , etc. .ite
hin 72 ho	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)		e <i>d)</i> ge (1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of woi DO NOT us	al Occup rk done o se retired	ation during mos ()	t of work	ing	6b. Kind of B	usiness/Ir	ndustry
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should be ind Mental is marked or umatic eve	၉		rvey	Ma	acIvor			Maı		PARALLE.		<u>lacLe</u>	
2 s s s s s s s s s s s s s s s s s s s	1	19a. Informant's Name/Relation:								al Route Number,	-		
s 1 and of Health item 27 other ti	1	Karen M. Turne  20a. Method of Disposition	r/daugnt							ridgeport Date 2	Oc. Location		
Pages nent of P ant: If ite		1 ⊠ Burial 2 ☐ Cremation		om State	20b. Place of Disp cemetery, cre			Θ)					
permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (3	The second second	1	Queen of	Heav 2. Name an		ss of Facili			ittsbu		
permit. Pages Department of Importent: If i any injury or one		Bulle	A Lles	Lu Cur					J	tewart Fu Dakland,			
Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis	complications the	at caused the							st,		Approximate Interval Between Onset and Death
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ite be executed sysicien and he burial-transit	icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	50 No	consequence of):	ur th	n +	צ'ב					years
ath certifica	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Li	outcome of posterior of outcome of posterior of posterior outcome outc	Fetal death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>						ite of deliventh	ery Day Year
luires that the den signed by the a	۾	Part II. Other significant condite S	ons contributing to	to death but r	not resulting in the	underlying c	ause giv	en in Part I			acco use con s 2 □ No	tribute to t	the cause of death?
The law requii te has been s age 2 should	Completed	anencia								24a. Was an autopsy perform 1 Yes 2	ed?	Were autoprior to codeath?	opsy findings available ompletion of cause of 2□ No
iclen: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	ıl					26. Place	of Deat	h (Check only one			
tysic lis ce direc	2	1 ☐ Yes 2 ☐ No	Hospital: 1	□Inpatient	2 ER/Outpatie	nt 3□ DC	A Oth	9r: 4 X NL	irsing Ho	ome 5 🗆 Resider	nce 6 □Oth	ner (Speci	fy)
ling After fune	Certification:	Z Accident	igation	ate of Injury Month, Day Y	(ear) 28b. Time (	of 2	8c. Injur Worl	/at k? Yes 2□	No	28d. Describe hor			
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Certifi		nined 289. P	lace of Injury uilding, etc. (	· At home, farm, si Specify)	reet, factory	r, office			28f. Location (Str City or Town,		oer or Run	al Route Number,
To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I	Medical		Exeminer: On th		ny knowledge, dea kamination and/or it d.								
vithin o the ompl	ĕ Z	29b. Signature and title of certific	or //	-		290	. Licens	e number	_		d. Date signe		
- 3 - 0		Marcent	a Kn	-10	10		02	665	0		4/2	0/2	004
		30. Name and address of person	who completed of	cause of deat	th (Item 23a) (Type	Print)	rett	Hig	-	ry Qas	klaus	e.M	1004
Stat	e	31. Date filed (Month, Day, Year	) 3	2. Registrar's	Signature			0		1		1	
Registra		APR 2	0 2004	Postlos	A. A.	hounds	a						

Physici		1 - State Registra AMEND ITEM #3  1. Decedent's Name (First, Middle, La Mary Jane McCann		L <i>3                                    </i>	04 040	imodio				2. Date of De Month April	Day		3. Time of Dea
/Medic Examin	er	4a. Facility Name (If not institution, ght 441 N. Potomac St 5. Social Security Number 6.3	reet, Apt	. 14	last birthday)	Hage:	rsto	If Under	24 Hrs.	8. Date of Bir	4c. W	County of Dee Jashingt 9. Bir	th
Funeral Director			1□M 2 <b>X</b> F	78	Yrs.		Days	Hours	Min.	107277	1925		10d. Inside City
23a or 28a-f ahow	irector	MD Washingt	con		gersto		Code				10g. Citi	izen of What Co	1 🖾 Yes 2 [
ene. than "naturel", or items 23e or 28a-f ahow na Medical Examiner nast be nutified at	by Funeral Director	441 N. Potomac St  11. Marital Status  1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces' 1  Yes 2 11	Ever in U.				spanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	cify Yes or No Rican, etc.)	US	14. Race - Ame Black, Whit	
jiene. r than "naturel", or items tra Madical Examinar na	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr  Elementary/Secondary (0-12)	Year or Dates:	5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupa done d retired	ition luring most		ng		ind of Business	/industry
ital Hygi id other avent, I	То Ве Соп	Unk.  17. Father's Name (First, Middle, Las. George Newton McC				Machi	ne C	18. Mothe	r's Name	(First, Middle Lte Hal	, Maiden	lanufact Sumame) Baxter	uring
27 is m		19a. Informant's Name/Relationship Alfred G. Colon			441 N	I. Pot	omac	Stre			4, H		own,MD 217
0		20a. Method of Disposition  1 □ Burial 2 ② Cremation 3 [  4 □ Donation 5 □ Other (Special Content of the Conten	fy)		Place of Dispo emetery, crer thsbur	g Cre	matc	or.	4/30/	2004	Smi	thsburg	g, MD
Department Important: hang injury o		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or con	14/5	)_	30	)5 N.	Poto	mac S	Stree	et, Hag	erst	own, M	neral Hor 21740
nysician Medical xaminer e prijal-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as c.	n tas s a consequence s a consequence	uence of):	Can	u	<i>, P</i>	Ai men	y lung			Interval Between Onset and Deat
24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia tely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	I death 3	Ectopic pre					4	23d. Date of dei Month	iivery Day Year
been signed should be de	þ	Part II. Other significant conditions A 5 cets and	_		_		use give	n in Part I.		23e. Did t	/		the cause of death
cate has be	Completed									24a. Was auto perfo 1 Yes	osy ormed?	prior to death?	atopsy findings avail completion of cause 2 \( \sum \text{No} \)
r this certificate ral director, pag	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No  27. Manner of Death			ER/Outpatier		Othe	<sup>IC</sup> 4 □ Nu	rsing Hon	Check only one 5 Resi	dence 6	3 □Other (Spec	cify)
within 24 hours after death.  7 to the Funeral Director: After th completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not l 4 Homicide determined	28e. Place of In		Injury	М	Work 1 🗆 Y	? ′es 2□t	10		Street and	d Number or Ru	ural Route Number,
24 hours a Funeral of etely filled	Medical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysicien: To the best miner: On the basis of and manner si	of examina	wledge, death	n occurred at vestigation, i	t the tim in my op	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s) date and	and manner as	s stated. to the cause(s)
within To the comple	Me	29b. Signature and title of certifier	216					number Z-6 5	579			e signed (Monti	h, Day, Year)
1		30. Name and address of person who			No AT (		4// )						

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			For Stata	State of Ma				•	2001	1000
_			Ragistrar		Ce	rtificate of	Death		Reg. No. UU	+ 16995
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea	Day Yea	
-	/Medic		Paul Bryan Pa			1		May 8,		5:40P M
	Examir	ner	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death		4c. County of De	eath
			Harford Memor	ial Hosp	ital	Havre If Under 1 Year	de Grac	e	Harfor	
	Funeral		5. Social Security Number 6. Sex	M 2□F	(In yrs. last birthday	Months Days	Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)
	Director		274-36-6745 X		62 Yrs.			March	15, 1942	2 Canada
	fand •••		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
1	Many -f sh	ţ	MD Cecil		Perryv	ille				1X Yes 2 □ No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
1	death with the Maryland ems 23a or 28e-f show it must be notified at	Ξ	400B Carter Co	urt		21903	3		U.S.A.	
0	deat	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ar Black, W	merican Indian,
ွဲ့ပွဲ	or ite	臣	1 ☐ Never Married 2 ☐ Married	1  Yes 2 No	1960-	1 ☐ Yes 2 X No		, , , , , , , , , , , , , , , , , , , ,	Specify: _	
5-0036	n 72 hours after death with the Marylan "natural", or Items 23a or 28e-f show Rajical Evanimer must be motified at	d by	3 ☐ Widowed 4 🏋 Divorced	Year or Dates:	1961				V	White
7 17	72 h	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	nation during most of work	king	16b. Kind of Busines	ss/Industry
35		m d	Elementary/Secondary (0-12)	College (1-4or 5+	)				Pichmond	Hill Mano
42			1 1 17. Father's Name (First, Middle, Last)		Gro	undskeer		e (First, Middle,	Maiden Sumame)	niii Manoi
2	e d la b	Be							,	
	D Z Z Z	2	George Page  19a. Informant's Name/Relationship (Type	ne Print)	19b Mail	ing Address (Street	Mary C		or, City or Town, State	a. Zip Code)
d ≥	nd 2 sho alth and 27 Is m				2015281	SE 5555 IN			1500	
Q.	2 4 8 E B		Barbara Stiles/ 20a. Method of Disposition	Companio	20b. Place of Disp	osition (Name of		Date	20c. Location - City	1D 21903 or Town, State
# 10	Pages nent of int: If it		1 Burial 2 Cremation 3 R	emoval from State		matory`or other plac Cemetei	1	17 20	04 617	ton MD
S #	it. P. intan intan		*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	A .		2. Name and Addre		17, 20	O4 EIK	ton, MD
W 2	permit. Pages Department of I Important: If ite any injury or of once.	ļ.,	- Inthe		1	7 - 7 (	T Coo E	uneral	Home, F	.A.
11			23a. Part 1. Enter the disease, or complied the complete	cations that caused t	he death. Do not er	259 East	Main S	or respiratory ar	kton, MI	proximate
01			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line	Gastrol	1001	1 60.00	1 00	_	Interval Between Onset and Death
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9 8	tificat ig phy as th						<del></del>			
B S	h cer endir use	Ş	23b. was decedent pragnant	3c. If yes, outcome of 1 ☐ Live bich 2	foregnancy	☐Ectopic pregnancy	,		23d. Date of o	,
<	deat death	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti 9☐Unknown	me of death 5	Other (specify)	· 		Month	Day Year
200	at the by th	Physician/Med	9 Unknown							
<i>y</i>	as tha gned	by	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause giv	en in Part I.			to the cause of death?
r	equir en si ould I	le d		Liver	cerra	2363			′es 2□No 3🔀	Probably 4 □Unknown
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<u>.</u>	lan: artifica ctor.	Be	25. Was case referred to medical examiner?		0	0	26. Place of Deat			
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	ng Pl		27. Manner of Death NZNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	k?	28d. Describe h	ow injury occurred	
Division of Vital Records	endi eath. or: A	Certification:	2 Accident investigation				Yes 2 □ No			
<u>.</u>	r Att ter d irect irect	T T	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or . m, State)	Rurai Route Number,
	urs af		and the same of	N.			1			
	Hosp 4 hor Fune Fune	edical	(Check only 2 Medical Examin	ner: On the basis of e	examination and/or in				cause(s) and manner date and place, and d	
	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Med	one) 29b. Signature and title of certifier	and manner state	<del></del>	29c. Licens	e number	- 2	29d. Date signed (Mo	nth, Day, Year)
	T W 7			ma AB	219	DZ.	3115			
	^		30. Name and address of person who co		ath (Item 23a) (Tunn	Print)				
	110		30. Name and agreess of person who co	1	Han	e de C	nnee,1	200	5-9-04	
	Sta	ate	31. Date filed (Month, Day, Year)	22. Registrar	's Signature	4.	/	-		
	Pagist		MAY 1 9 2004	Mar.	M. Dog	Red .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Mary A. Peters 1:50A May 12 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Center Ceci1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director 208-22-1853 79 1924 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, it a Modical Examinar must be notified at 1X Yes 2 □ No **Funeral Director** MD Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 150 E. Main St. 21921 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiena.

is marked other than 6 Owner/Operator Peters Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in nent of Health and Mental I 9 Clark Troxel No information available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other trae 202 Brown St., F1kton, MD ace of Disposition (Name of Date John C. Peters/Son 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bannerville Pennsylvani 4 ☐ Donation 5 ☐ Other (Specify) Bannerville Cemetery May 18, 2004 21. Signature of Fundral Service L 22. Name and Address of Facility Andrew G. Gee Funeral Home, Eleval or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause the challenge. 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 signad by the attending physician Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day jo in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) detached ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 1 Yes 2 No 3 Probably 4 Whiknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 4 1 Yes 2 No 1 ☐ Yes filled in by the funeral director. 25. Was case referred to medical 26 Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident s after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) ly Ave, ELKTON, MI) 21921-K. VATELMD 123 Singer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 3 2004 Registrar

			For State	State of Ma	arylan	•	artment or			nd Mei		iene	onni.	10007
	Physicia /Medic	al	1. Decedent's Name (First, Middle 4a. Facility Name (If not institution	K Proct	OR		4b. City, To			a	Date of Deal Month	th Day	Year 2000	11.20
	Examin Funeral Director	er	7705 Old Alexand 5. Social Security Number 220–50–5813	dria Ferry R		last birthday) Yrs.	Clin	ton Year I	If Under 2 Hours	4 Hrs. 8	Date of Birth (Month, Day, oer 29		nce Geo	orges hplace (State or Foreign unitry) yland
-61212 pu	nours are bean win the mayand ture!, or iteme 23a or 28e-f show al Extrailmer in ust be notified at	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number	Georges	1	, Town or Lo		ode			1	0g. Citize	en of What Co	10d. Inside City Limits 1 X Yes 2 □ No nuntry?
		by Funeral Directo	3 ☐ Widowed 4 ☐ Divorced Year or Dates:						Mexican, Puerto Rican, etc.) Black, V				Black, Whit	
	within 72 ene. than ne'	Completed	15, Decedent (Specify only highes Elementary/Secondary (0-12) 12	's Education t grade completed)  College (1-4or 5	5+)	(Give life.	dent's Usual ( kind of work DO NOT use emaker	Occupation done dur retired)	on ring most	of working			of Business mestic	Industry
	jes 1 and 2 should be filed tof Health and Mental Hygi If item 27 is marked other or other treumatic event, II	To Be C	17. Father's Name (First, Middle, Camillus 19a. Informant's Name/Relations	F.			octor	S	alome	9	irst, Middle, I	Harl	ley	Zip Code)
ď			Alethea Conte	ee/Daughter 3 □Removal from State		lace of Dispo emetery, cre	osition (Name matory or othe	of er place)	i	Date	175-7	20c. Loca	ation - City or	
Baltimore,	permit. Pages Department of t Importent: If its any injury or of once.		4 □ Donation 5 □ Other (State of Funeral Service)     Oderson 6	pecify)	MO13	2	tion Co 2. Name and A dams Fu	Address	of Facility					
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):								Approximate Interval Between Onset and Death			
of Vital Records, P.O. Box 68760,	physician and sthe burial-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						Se			74/		
	death certif ie attending ad for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23	23d. Date of delivery Month Day Year			
	To the Hospital or Attending Physicien: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detached.	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacc								o use contribute to the cause of death? 2 以 ON 3 □ Probably 4 □Unknown			
		e Completed	25. Was case referred to medical						OC Place	of Dooth (		ned?	24b. Were au prior to death?	stopsy findings available completion of cause of
		Certification; To B	examiner?  1   Yes 2   No							ence 6[	e 6 □Other ( <i>Specify</i> ) njury occurred			
Divis														
		Medical		Examiner: On the basis o and manner st	f examina		vestigation, in	my opin	nion, death	h occurred	at the time, d	ate and p	lace, and due signed (Monti	h, Day, Year)
'n	P3		30. Name and address of person	nice St	AK	ir			565 + 15 m/1	ER SPK	Term NO.	ANE S M	ED CO	1,2004 _
	Sta Registi		31. Date filed (Month, Day, Year)	7 2004 32. Regist	ar's Signa	ture	Acordi							

				. For	State of Ma	aryland / D	epartment o	of Health and N	/lental Hy	/giene			
				State Registrar		(	Certificate	of Death		Reg. No. 2	no.	15000	
		Physici	an	1. Decedent's Name (First, Middle, Last)	11 -	Pinke	H JE		2. Date of D Month	Day	Yeer	3. Time of Death	
		/Medic		Driscoe  4a, Fecility Name (If not institution, give s	٧٧٠			wn, or Location of Death	April	23 2004 4c. Coun	ty of Deeth	1:30 PM M	
		Examir	ier	Wicomico Nursing Home	·			sbury		Wic	omico		
	•	Funeral	П	5. Social Security Number 6. Sex	7. Age	e (In yrs. last birth	day) If Under 1 Y		8. Date of B (Month, D	irth	9. Birth	place (State or Foreign ntry)	
		Director		215 - 03 - 7356 19 Usuel Residence of Decedent		86 1	rs.		11-	12-17		laryland	
		/land		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits	
		within 72 hours after death with the Maryland ene. than "naturel", or Itams 23a or 28a-f show he Marical Exercites from the notified at	tor	Maryland Somer	set	Pri	ncess	Anne.				1 ☐ Yes 2 No	
			Director	10e. Street and Number	1	01	10f. Zip Co	ode		10g. Citizen o	What Cou	ntry?	
			eral	13559 Bob	Town  2 Was Decedent	Fuer in IIS	13 Was Deceden	1853	necify Yes or N	0 14 B	sce - Ameri	can Indian	
	10		Funeral	11. Marital Status  1 Never Married 2 Married	<ol> <li>Was Decedent E Armed Forces?</li> <li>1 ☐ ¥es 2 ☐ N</li> </ol>	10		t of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)		ack, White,	etc.	
4	036		l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1943-45	1 □ Yes 2 □	No Specify:		Spec	ity: R	lack	
5	21215-0036		Completed by	15. Decedeni's Educ (Specify only highest grade	ation completed)	16a. 0	Decedent's Usual C Give kind of work of	occupation done during most of work etired)	king	16b, Kind of	Business/In	ndustry	
2	12	within iene. r than	ошо	Elementary/Secondary (0-12)  7th Grade	College (1-4or 5	+)	Labor			Sea	Food	Tudosta	
A		Hyg the	BeC	17. Father's Name (Pirst, Middle, Last)	0	6		18. Mother's Nam		e, Maiden Suma	me)	/	
6	ylar	Department of Health and 2 should by My Department of Health and 2 should be a partment of Health and 2 should be a partment of the annual by Dance.	To E	Briscoe W.	Pinke	ett Se		Ste	lla	Gam.	e		
DE	Maryland			19a. Informant's Name/Relationship (Typ. Georgia Pinke	. ~			treet and Number or Rui		Λ.			
~	77.0			Georgia Pinke 20a. Method of Disposition	17 - 61	20b. Place of I	3559 Disposition (Name of	Bobtown	Date	20c. Location		Anne Md own, Slate	
	Б			1 □ Burial 2 □ Cremation 3 □ Re  '4 □ Donation 5 □ Other (Specify)	moval from State		crematory or other		27/04	Hor	-lock	nol.	
P	Baltimore,			21. Signature Funeral Service License	. 1-01			ddress of Facility	nthan	1 E. V	lard	F.H.	
				23a. Pert1. Enter the disease, or complic	ations that caused	the death. Do no	t enter the mode of	tampden f dying, such as cardiac	or respiratory	Prin.	255 1	Approximate	
				shock, or heart failure. List only on Immediate Cause (Final	e cause on each Min	10.	ENCE BRAC		12001	400		Interval Between Onset and Death	
	1			disease or condition resulting in death)	Due to (or as	a consequence of		HEI	10/5/-	NUIE			
			<b></b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
			Examiner										
	Ć,	ite be executed lysician and he burial-transit	Exai	that initiated events c. resulting in death) Last		a consequence of	):						
	376	h certificate be e: ending physician use as the buria	cal	d									
	Box 68760,		Med	IF FEMALE:	3c. If yes, outcome	of pregnancy							
	Bo	attend for us	clan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregr 5 ☐ Other (specif			l l	ate of delivi	ery Day Year	
	P.O.	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysl	1 Yes 2 No 9 Unknown 9 Unknown 5 Unier (specify)									
	s, P		by Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							cco use contribute to the cause of death?		
	ord		eted	TYVERTENSIVE HEART DISEASE 10 Yes							2 No 3 Probably 4 Minknown		
	3ec		Completed						24a. Was		prior to co death?	ppsy findings available impletion of eause of	
	la			25. Was case referred to fiedical				26. Place of Deat		2 2 No	1 🗆 Yes	2 N/No	
	>		To Be	evaminer?	ospital: 1  Inpatie	nt 2 ER/Outp	atient 3 DOA	Other		idence 6 🗆 O	her (Specii	(y)	
	O		L:uo	27. Mannes of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Tir	ury	Injury at Work?	28d. Describe	how injury occu	rred		
	sio		catl	2 Accident investigation 3 Suicide 6 Could not be	One Blace of Inju	.m. Athana (	М	1 ☐ Yes 2 ☐ No	29f Looption	(Change and Miss	has as Our	-I Pauta Number	
	Di⊻		Certification:	3 Suicide 4 Homicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)									
			Medical C									stated. to the cause(s)	
		o the o the omplet	Med	one)  29b. Signature and title of certifier	and manner sta	ned.	29c. Li	cense number		29d. Date şign	ed (Month,	Day, Year)	
1		<b>⊢ ≤ ⊢</b> ō		Milalaste	Asi	M	D-	-0060515	>	4/2	s bc	ŕ	
				30. Name and address of person who con			ype, Print)			1	1		
				Mahesha Thimmarayapp  31. Date filed (Month, Day, Year)		314 Eastern ar's Signature	shore Dr	Salisbury MD 2	21804				
		Sta Regist		APR 2 6 2			book	,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** McDonald Riale May 0041 М Theodore 14 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 912 Nesbitt Road Cecil Residence Colora If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 22, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplece (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F Yrs 220-24-0180 75 June Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show siner must be notified at 1 Tyes 2X No Colora Directo Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 21917 or itams 23a 912 Nesbitt Road U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exertimet once. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Completed by White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground Elementary/Secondary (0-12) College (1-4or 5+) Aberdeen, Maryland Steam Fitter/Plumber Eleven Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William James Riale, Sr. Minnie E. Graybeal 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Riale (wife) 912 Nesbitt Road, Colora, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Buriat 2 □ Cremation 3 □ Removal from State West Nottingham Cemetery 05/18/04 Colora, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Lee A. Patterson & Son Funeral Home, P.A. Perrvville, Maryland 21903-0766 21. Signature of Funeral Service Licensee Thomas N. Jatterson Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No õ Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 90 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 → No 3 DOA 2 ER/Outpatient this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Natural Injury 1 ☐ Yes death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Course 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 THUMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Clifton Palmer Month Rizer /Medical 04 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SACRED HOSPITAL HEART CUMBER LAND ALLEGAN) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 30 1 5. Social Security Number 7. Age (In yrs. last birthday)
76 Yrs. 6. Sex **Funeral**  Birthplace (State or Foreign Country) 722-12-8785 1**XX** 2 □ F Director 30 1927 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show the Medical Examiner: ust be nutilised at 10d. Inside City Limits MD Garrett Bloomington Director M☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Pattison 21523 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1₹XYes 2 □ No WW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2√2√No Specify: þ Specify: 3 X Vidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Michal 2009. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel unknown Fitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Palmer Rizer Opal L. (Clark) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifton T. Rizer / son HC 3, Box 59, Marienville, PA. 16239 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 05/10/ Rest Lawn Mem Gardens Cumberland Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee Wa 111 Church St., Westernport, Maryland 23a. Part1. Enter the disease, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MITAN TATIC **Physician** TONGUE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learn, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequency of burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 Yes 2 No 1 Yes 2 100 the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 Inpatient this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier f per on who completed cause of death (Item 23a) (Type, Print) STON DRIVE CUMPARIAND, NO 2100 MAGBOJOS 1RGINLA 912 4-32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 Registrar